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Nursing Facility Enforcement before the Department of Health and Human Service Appeals Board - The Breakdown of Administrative Procedure Act Standards, and Modest Proposals to Accommodate Agency Prerogatives with Fundamental Fairness

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ARTICLES

NURSING FACILITY ENFORCEMENT BEFORE THE DEPARTMENT OF HEALTH AND HUMAN SERVICE APPEALS BOARD - THE BREAKDOWN OF ADMINISTRATIVE PROCEDURE ACT STANDARDS, AND MODEST PROPOSALS TO ACCOMMODATE AGENCY PREROGATIVES WITH FUNDAMENTAL FAIRNESS

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ABSTRACT

Skilled nursing facilities (commonly called nursing homes) are said to be the second-most regulated businesses in America, second only to nuclear power plants. Such facilities are subject to comprehensive federal regulation at 42 C.F.R. Part 483 (the "Long Term Care Requirements of Participation") that govern virtually every aspect of facility design, staffing, programming, service delivery, resident rights, and even resident outcomes. That degree of regulation reflects public demand that the government has a responsibility to protect frail, elderly residents, and also the demands of federal and state governments as customers, since they pay for the care of more than three-quarters of nursing facility residents through the Medicare and Medicaid Programs.

The Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (DHHS) has regulatory authority to enforce the Long Term Care Requirements of Participation, including the authority to impose a variety of "remedial" sanctions tailored to the "severity" and "scope" of noncompliance. The Social Security Act, and CMS' regulations, in turn, provide for an administrative appeal process before the DHHS "Departmental Appeals Board" (the Board) by which nursing facilities can challenge sanctions with which they disagree. In that process, an administrative law judge conducts a trial-type adjudication, and then a panel of the Board itself reviews the ALJ's Decision.

In a perfect world, CMS would win every nursing facility enforcement appeal because inspectors would cite violations of clear standards; supervisors would weed out weak cases; the agency would offer sufficient evidence and argument to meet any applicable standard of review; and ALJs

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would issue well-reasoned and supported decisions. But over the years, as the number and complexity of the regulations and accompanying agency directives—and appeals—has ballooned, the enforcement and appeal process has become sloppier. Some agency guidance is ambiguous or allows inspectors great room for "judgment." Overworked inspectors make factual mistakes or can be unfamiliar with current standards of clinical practice. Regulators can have unrealistic expectations. Imposition of sanctions can be unpredictable, subjective and even arbitrary in specific cases. And ALJs can be result-oriented.

This paper addresses a more glaring *legal* flaw in the administrative appeal process. Every court that has addressed the question has held that the Board's administrative review process is governed by the substantive and procedural requirements of the Administrative Procedure Act (APA). But in recent years, the Board has held in a series of cases that it is *not* subject to even the most basic of those standards. For instance, the Board says that it can review sanctions de novo, and may substitute otherwise-prohibited "post hoc rationalizations" to "fix" flawed agency actions. It says that it may "presume" that CMS' allegations of noncompliance are true, that the agency has no burden to support them, and that a petitioner challenging agency action has the burden to "persuade" it otherwise—all directly contrary to APA standards. Not coincidentally, during the past decade, the Board has reversed *every* ALJ Decision in favor of a nursing facility that CMS has asked it to review.

Courts traditionally have been reluctant to interfere with an agency's legitimate enforcement prerogatives, particularly where, as here, a specific enforcement action involves application of specialized regulations in an area within the agency's expertise. But nursing facilities dissatisfied with the Board's cutting of procedural corners are appealing more and more cases raising APA issues to the courts, and the courts now are addressing such issues. The premise of this paper is that it is in the best interests of all—CMS, the Board, regulated entities, and the residents whose interests ultimately are at issue—that the Board reform its processes, and conform with the APA, before the courts do so on an ad hoc basis.

I. INTRODUCTION

Skilled nursing facilities (commonly called nursing homes) are said to be the second-most regulated businesses in America, second only to nuclear power plants.[1] Such facilities are subject to comprehensive overlapping

1. The media, and much of the public, sometimes do not distinguish among "nursing facilities," which are highly regulated facilities that provide "hands on" nursing and

federal, state, and local regulation of virtually every aspect of facility design, staffing, programming, service delivery, resident rights, and even resident outcomes.[2] That degree of regulation reflects not only the universal public demand that the government has a responsibility to protect frail, elderly residents from abuse and exploitation,[3] but also the demands of federal and state governments as customers, since they pay for the care of more than three-quarters of nursing facility residents through the Medicare and Medicaid Programs.[4]

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rehabilitation therapy services, as opposed to assisted living facilities, rest homes, retirement communities, personal care homes, and other congregate facilities that also serve elderly or disabled persons. The latter generally provide less intensive medical services (if any), are much less regulated by the states, and are not regulated at all by the federal government. According to the U.S. Department of Health and Human Services (DHHS), there are about 15,600 nursing facilities nationwide serving about 1.35 million residents at any given time and about twice as many assisted living and similar facilities serving an unknown number of residents. U.S. DEP'T OF HEALTH AND HUMAN SERV. NAT'L CTR. FOR HEALTH STAT., VITAL HEALTH AND STAT. SER. 3, NO. 38, LONG-TERM CARE PROVIDERS AND SERVICE USERS IN THE UNITED STATES: DATA FROM THE NATIONAL STUDY OF LONG-TERM CARE PROVIDERS, 2013-2014 (2016) [hereinafter NCHS REPORT]. The discussion in this paper is limited to federal regulation of nursing facilities.

2. Persons who live in nursing facilities are called "residents" for regulatory purposes. The NCHS Report indicates that two-thirds of nursing facility residents are women, about half are over age 85, and about 15% are under age 65. *See* NCHS REPORT, *supra* note 2.

3. "Nursing home abuse and neglect" is a perennial topic of media reports, political attention, and plaintiffs' lawyer advertising. For instance, one plaintiffs' law firm's website warns that 10 million nursing facility residents are abused each year (eight times the total number of residents). *See* NURSING HOME ABUSE CTR., http://www.nursinghomeabusecenter.com (last visited Mar. 22, 2019). The actual number of even alleged abuse and neglect cases—by any definition, with even one, of course, being too many—is far lower, and less than 10% of such allegations ever are substantiated. One problem is definitional; for instance, various state laws, professional associations and authors define "sexual abuse" to include everything from inappropriate jokes or greeting cards, to vulgar remarks and threats, to unwanted nudity or forced photography, to physical contact including kissing and fondling, to actual criminal rape. In fact, the most common allegation of sexual abuse in nursing facilities involves resident-to-resident kissing and fondling. *See generally* Robert A. Hawks, *Grandparent Molesting: Sexual Abuse of Elderly Nursing Home Residents and Its Prevention*, 8 MARQ. ELDER ADVISOR 159, 172 (2006); NCCD, *The Study of Sexual Abuse of Vulnerable Adults in Care Facilities*, VIMEO (Apr. 20, 2011), https://vimeo.com/36486508 (Nat'l Council on Crime & Delinquency webinar by Dr. Holly Ramsey-Klawsnik & Dr. Pamela Teaster from the Nat'l Comm. for Prevention of Elder Abuse).

4. Medicare, the federal health insurance program for persons age 65 and over and some disabled persons, covers limited post-hospitalization long term care services, usually for rehabilitation following a hospitalization. Medicaid, the cooperative state-federal medical assistance program for persons who meet certain income and asset limits, pays for nursing facility care for qualifying beneficiaries who meet threshold medical criteria. According to

No one disputes that regulation of health and safety for elderly persons in nursing facilities is a vital governmental function. Nursing care is provided by people who make mistakes, have bad days, and can be overwhelmed by emergencies; and even one bad apple abusing or neglecting a vulnerable resident is one too many. But over the years, as the number and complexity of federal and state regulations and accompanying directives has ballooned, some regulations have become obsolete and do not directly address the circumstances of modern nursing facilities or current standards of resident care. Some regulations are ambiguous or allow inspectors, known as surveyors, great room for administrative "judgment." Surveyors can make mistakes or be unfamiliar with current standards of practice. Moreover, regulators can have unrealistic expectations (or political axes to grind). And imposition of sanctions for violations can be unpredictable, subjective, and even arbitrary in specific cases.

Whether the current regulatory system—or any regulatory system—can address and resolve all human performance issues, even in a critical area such as health care, is beyond the scope of this Article. Instead, this paper focuses on one aspect of this regulatory regimen, the appeals process by which nursing facilities can contest what they believe to be unwarranted or excessive "enforcement" sanctions imposed by the Centers for Medicare and Medicaid Services (CMS) for violations of the federal "Long Term Care Requirements of Participation."[5] In some ways, this one small area of administrative litigation vividly illustrates how an increasingly authoritarian, yet resource-strapped bureaucracy, cuts legal corners and minimizes oversight of its

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DHHS, 96.9% of nursing facilities participate in the Medicare Program, and 95.1% participate in the Medicaid Program (the balance serves only private pay or charity residents). *See* NCHS REPORT, *supra* note 2. Nationwide, Medicaid pays for the care of about two-thirds of nursing facility residents, and Medicare another 10% or so (the balance pays privately, with insurance, or charity care), although those percentages vary from state to state and facility to facility, depending on the specific services the facility provides.

5. Various "chapters" or "parts" of the Medicare regulations set forth "conditions of participation" that various categories of health care providers—hospitals, home health agencies, hospices, and the like—must meet to "participate in" the Medicare and Medicaid Programs. For nursing facilities, these requirements are called the Long Term Care Requirements of Participation and are found at 42 C.F.R. pt.t 483. *See* 42 C.F.R. § 483 (2016). As discussed in the text, CMS amplifies and explains these regulatory requirements in thousands of pages of "Interpretive Guidelines," notices, directives, memoranda, and the like. While the latter are not legally binding on nursing facilities because they are not promulgated pursuant to the notice and comment provisions of the Administrative Procedure Act, CMS does consider such informal directives to be authoritative interpretations of the regulations and does direct inspectors to evaluate compliance by them. *See e.g.*, CTR. MEDICARE & MEDICAID SERVS., *State Operations Manual*, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf.

actions. The premise of this paper is that this insulation of agency action from effective oversight is caused less by any particular administration's politics or policies than by the difficulty—some would say impossibility—of effective outside review of agency decision-making at the complex intersection of law and science. For instance, the agency can paint its specific enforcement activities in very broad strokes, such as protection of resident health and safety.

As discussed below, a series of recent judicial decisions illustrates the practical and legal difficulties that courts face when designing remedies where CMS, overwhelmed by inadequate resources, uses legal and evidentiary shortcuts to dispose of (or simply not to decide) administrative appeals. Not incidentally, CMS thereby prevents, limits, or delays judicial review of its actions (which itself has due process implications). This Article suggests that the agency has the tools to address and fix its problems—before the courts step in, as they increasingly are doing—and, specifically, that the Administrative Procedure Act (APA)[6] provides the necessary structure for appropriate administrative decision-making.

II. BACKGROUND

A detailed review of the history and content of nursing facility regulation is beyond the scope of this Article, but some history is useful to put the shortcomings of today's regulatory and appeals processes into perspective.[7] Prior to the 1970s, most "old age homes" and the like were operated by religious or voluntary organizations or local governments, for instance, "poor houses." Congress enacted the Medicare Program in 1965 to provide basic health insurance to elderly persons. At that time, elderly persons were the poorest age cohort in America, largely because any health issue could be economically devastating.[8] But Medicare provided, and provides, only limited coverage for post-acute care, generally limited to 100 days per year for post-hospital care in a nursing facility, usually for rehabilitation from surgery or an acute event such as a stroke. In 1966, Congress enacted the Medicaid Program as an adjunct to Medicare to pay for certain services that

6. 5 U.S.C. §§ 500 et seq. (1946).

7. As discussed in the text, Congress largely based the current regulatory process on a landmark 1986 report by the Institute of Medicine. *See* INST. MED., IMPROVING THE QUALITY OF CARE IN NURSING HOMES app. 1 (1986) [hereinafter IOM REPORT] (summarizing the history of long-term care).

8. *See CMS' Program History*, CTR. FOR MED. HISTORY, cms.gov/About-CMS/Agency-information/History (summarizing the history of Medicare) (last visited Mar. 22, 2019).

Medicare did not cover for poor people.[9] It was not long before entrepreneurs realized that many elderly persons who required long term nursing care qualified for Medicaid, and so through the 1970s and 1980s the number of nursing facilities—about two-thirds of which now are operated as for-profit businesses—grew rapidly, to the point that Medicaid reimbursement for nursing facility services is now one of the largest line items on most states' budgets.[10]

At the same time, real and perceived abuses of the Program grew: incompetent operators; untrained or insufficient staff; financial exploitation and other "resident rights" issues; and a variety of clinical concerns, including lack of a uniform resident assessment instrument, inconsistent care planning, and inadequate registered nurse coverage and physician oversight. Resident advocacy groups such as the National Citizens Committee for Nursing Home Reform began to publicize such concerns and tied them in large part to the lack of effective federal regulatory requirements.[11] These concerns focused on substantive requirements as well as the lack of effective enforcement mechanisms. For instance, early Medicare regulations required only that a facility have certain policies and procedures in place but did not address how well the facility actually implemented such policies.[12] Elder rights advocates

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9. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., *Program History*, MEDICAID.GOV, https://www.medicaid.gov/about-us/program-history (last visited Mar. 22, 2019).

10. The Medicare Payment Advisory Commission (MEDPAC) reports that Medicaid accounted for 28.7% of all state spending in FY 2016. In comparison, MEDPAC reports that state spending on elementary and secondary education totaled 19.6% of state budgets (local government school spending is much more in most states), and state spending for higher education totaled 10.5% of state spending. *See* medpac.gov/subtopic/medicaid-share-of-states-budgets. In recent years, between 30% and 40% of Medicaid spending has been devoted to long term care (the amount of long-term care spending continues to increase, but the percentage of total Medicaid spending devoted to long term care is declining, as most "Medicaid expansion" under the Affordable Care Act is for non-long-term care services). *See* Eiken et al., *Long-Term Services and Supports: 2015 Total Medicaid Spending,* MEDICAID.GOV, https://www.medicaid.gov/medicaid/ltss (last visited Mar. 23, 2019).

11. *See History*, THE NAT'L CONSUMER VOICE FOR QUALITY LONG-TERM CARE, https://www.theconsumervoice.org/about/history (summarizing consumer efforts to persuade Congress to address nursing home reform in the 1970s) (last visited Mar. 23, 2019).

12. At the same time, the legislative history to the current nursing facility enforcement statute, which is described in the text below, recites that Congress did not intend the inspection and enforcement process "to determine whether every nursing facility is in compliance with every requirement of participation. Instead, its purpose is to detect facilities where residents are not receiving quality care." H.R. Rep. No. 391, at 468 (1987), *reprinted in* 1987 U.S.C.C.A.N. 2313-1. As this paper illustrates, during the last 30 years, as widespread structural quality-related issues (inconsistent staffing requirements, lack of uniform resident assessment and care planning, lax physician oversight, overuse or misuse of psychotropic

focused on so-called "yo-yo" compliance, where surveyors repeatedly cited noncompliance at a facility—which suggested inability or unwillingness to comply—but the facility suffered no adverse consequences. At that time, the law basically limited sanctions for noncompliance to decertification or "termination" of an offending facility from the Medicare and Medicaid Programs—which CMS was reluctant to do because of the disruption and "transfer trauma" associated with involuntary resident relocation, and loss of jobs.[13] Indeed, the few courts that addressed potential decertifications at this time generally were reluctant to relocate residents involuntarily unless conditions throughout a facility were dire.[14]

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medications, and the like) have largely been eliminated from nursing facilities, the focus of the survey and enforcement process has drifted away from such systemic issues toward citation of allegedly inadequate individual resident outcomes (sometimes without sophisticated analysis of causation or inevitability) and specific instances of staff errors and omissions, poor judgments, or even second-guessing of professional judgments in specific cases.

13. *See, e.g.*, IOM Report, *supra* note 8, at ch. 5.

14. *See* Lexington Mgmt. Co. v. Dep't of Social Servs., 656 F. Supp. 36, 41 (W.D. Mo. 1986), where the court enjoined termination of Medicaid payments to a nursing facility pending the appeal of a Medicaid termination, on the ground that termination of payment would have required relocation of the residents. In characterizing the prevention of transfer trauma as a matter of public interest, the court explained:

> [N]ursing home residents are susceptible to a phenomenon known as "transfer trauma." This phenomenon -- which is oftentimes characterized by a refusal to eat, a general sense of disorientation, or a loss of one's will to live -- commonly affects nursing home residents who are suddenly forced to vacate familiar surroundings. Transfer trauma has even been directly linked to the deaths of some nursing home residents.

Likewise, in *Wayside Farms, Inc. v. U.S. Dep't of Health & Human Servs.*, 663 F. Supp. 945, 954 (N.D. Ohio 1987), the court noted that "transfer of some of the patients may be difficult for many and impossible for some." The court granted an injunction because "[p]reserving the status quo under these circumstances until the decision has been thoroughly considered avoids the transfer of patients. . . ." *Id. See also* Hathaway v. Mathews, 546 F.2d 227, 231 (7th Cir. 1976) (temporarily enjoining termination of Medicaid payments to nursing facility where involuntary relocation of residents "would create a major disruption in their lives."); Greenwald v. Whalen, No. 78-Civ.2765-CSH (S.D.N.Y. Jan. 26, 1979), *reprinted in* COMMERCE CLEARING HOUSE, CCH MEDICARE AND MEDICAID GUIDE ¶ 29,512 (1977) (enjoining reduction of Medicaid payments to nursing facility because "the involuntary transfer of aged, seriously ill patients is dangerous to them"); Burchette v. Dumpson, 387 F. Supp. 812, 819 (E.D.N.Y. 1974) (explaining that risk of transfer trauma constitutes irreparable injury because "[c]hanges in surroundings and movement of long distances of senior citizens who are suffering from physical and psychological infirmities are likely to aggravate their condition and increase the likelihood of death"); MacLeod v. Miller, CCH Medicare and Medicaid Guide ¶ 30,560 (Colo. Ct. App. May 22, 1980) (overruling trial court refusal to enjoin transfer of nursing home

In the late 1970s, the Carter Administration proposed "outcome oriented" regulations designed to address the actual impact of facility noncompliance on resident health and safety.[15] However, the regulations were not finalized before the Carter Administration left office, and the Reagan Administration withdrew the proposal as part of its "deregulation" efforts.[16]

In response, Congress commissioned a study of nursing facility quality by the Institute of Medicine of the National Institutes of Health. The Institute of Medicine published an exhaustive report in 1986 (the IOM Report) that identified dozens of structural and operational issues regarding staffing, quality of care, quality of life, resident rights, and regulatory compliance.[17] The IOM Report also made numerous policy recommendations, which Congress translated almost verbatim into legislative language included in the "nursing home reform" provisions of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87).[18]

These OBRA '87 provisions, which are scattered throughout the Medicare and Medicaid Titles of the Social Security Act, remain the substantive basis for nursing facility regulation today (even though residents, facilities and clinical standards of care have changed considerably in the interim). The statutory provisions include very detailed operational and clinical provisions, as well as detailed provisions for residents' rights, that provide the basis for what became known as the regulatory "Long Term Care Requirements of Participation," which were promulgated in 1995 and have been revised from time to time in the interim, most recently in 2015.[19]

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resident because the "psychological and physical side effects" of transfer trauma "would be immediate and irreparable").

15. New Directions for Skilled Nursing and Intermediate Care Facilities, 43 Fed. Reg. 24873 (proposed June 8, 1978) (to be codified at 42 C.F.R. pts. 405 and 449).

16. *See* Weiner, et al., "Nursing Home Care Quality," Henry J. Kaiser Foundation, December 2007, at 4.

17. COMM'N ON NURSING HOME REG., NAT'L INST. OF MED., IMPROVING THE QUALITY OF CARE IN NURSING HOMES (1986).

18. Pub. L. No. 100-203, 101 Stat. 1330 (Dec. 22, 1987). For several years during the 1980s, Congress accumulated all "must pass" legislation into a session-ending omnibus bill so that President Reagan could not veto individual measures. The nursing home reform provisions of OBRA '87 are included in Title IV of the Bill, including substantive requirements at §§ 4201 et seq.; survey and certification procedures at §§ 4202 et seq.; and enforcement provisions at §§ 4213 et seq. Most, but not all, of those provisions are codified in Title 42 of the U.S. Code, with most Medicare provisions located at 42 U.S.C. §§ 1395i-3 et seq., and most more or less parallel Medicaid provisions at 42 U.S.C. §§ 1396r et seq. There are additional provisions throughout the statute.

19. Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 80 Fed. Reg. 42168 et seq. (proposed July 16, 2015) (to be published at 42 C.F.R. pts.

OBRA '87 also includes "enforcement" provisions that set forth a rigorous inspection (or "survey") process and authorize the Secretary of Health and Human Services to impose a range of "remedies" or sanctions for noncompliance in addition to termination, including CMPs, directed plans of correction, denials of payment for new Medicare/Medicaid admissions, and others.[20] The notion was that a range of sanctions could be tailored to the "severity" and "scope" of noncompliance, replacing the previous provisions that provided only for termination from the Medicare and Medicaid Programs, in order to promote effective corrective of deficiencies rather than only punishment.[21]

The Secretary has delegated enforcement activities, including imposition of sanctions, to CMS. CMS, in turn, enters into contracts with "State Survey Agencies" to perform the actual inspections or "surveys," subject to CMS oversight.[22] Additionally, CMS has delegated day-to-day enforcement activities to its ten Regional Offices. This enforcement system triggers the appeals processes addressed in this Article.

This background provides the context for the administrative law issues addressed in this Article. Where Congress delegates enforcement authority to an administrative agency—that is, when Congress creates, and then delegates, the authority to impose fines or other penalties—that agency is then bound by the due process requirements of the Constitution. The courts generally are unwilling to frustrate an agency's legitimate enforcement prerogatives by imposing burdensome procedural requirements, so the courts have established minimal constitutional due process requirements for agency enforcement activities. These requirements typically include only notice of the grounds for the agency's action; some formal opportunity to contest the action before a neutral decisionmaker; some statement of grounds for the agency's final action; and generally—although not always—some

405, 431, 447, 482, 483, 485, and 488) (Final rule published at 81 Fed. Reg. 68688 et seq. (Oct. 4, 2016)).

20. 42 U.S.C. §§ 1395i-3(g) (2014),1395i-3(h) (2014), 1396r(g) (2011), 1396r(h) (2011).

21. However, as noted in note 12 above, it is unclear whether the Congress ever intended the enforcement process to focus on specific acts and omissions, or specific resident outcomes, as it currently does, as opposed to overall quality of care. Indeed, one of the authors of the IOM Report suggested to the author that using policy aspirations such as those set forth in the Report as the basis for sanctioning bad outcomes was "pushing a string," that is, that a focus only on punishing bad outcomes is, at best, an inefficient way to describe and incentivize desired outcomes. But as the discussion in the text illustrates, it is difficult to translate policy aspirations into a regulatory enforcement system, much less into an appeal process. IOM REPORT, *supra* note 8.

22. 42 U.S.C. § 1395aa(a) (2008).

provision for judicial review.[23] At the same time, overburdened federal courts are reluctant to open their doors to categories of agency enforcement cases for which agency adjudicators and administrative law judges ("ALJs") may serve, at least in the first instance, as effective substitutes for Article III judges.[24] The Supreme Court has indicated that courts generally should accord considerable deference to an agency's interpretation and application of its own regulations, especially where specific interpretation and application of a regulation is said to be within the scope of the agency's expertise.[25] Of course, application of these general rules can be problematic where, for instance, the agency is good at designing and describing inspection procedures, but has little specific knowledge or expertise about the circumstances of a specific patient's case, or the considerations that affected a physician's or a nurse's professional decisions in a case that an inspector is reviewing.

The questions where to draw the line between effective implementation of delegated statutory enforcement authority and "arbitrary and capricious" agency action; and how to facilitate effective oversight of an agencies' day-to-day decision making without unduly burdening the agency, are not new. Seventy years ago, Congress enacted the APA[26] largely to address concerns by Congress, regulated entities, and civil libertarians about administrative

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23. *See*, *e.g.*, Mathews v. Eldridge, 424 U.S. 319 (1976).

24. Congress created in the Social Security Act, 42 U.S.C. § 405(g) (1935), what the courts call a "channeling" requirement that generally requires exhaustion of the administrative appeal process before a court may review any CMS enforcement action. The history of application of this provision is extremely complicated; suffice it to say that for decades courts, including the Supreme Court, carved out various exceptions, including for certain nursing facility appeals. *See*, *e.g.*, Mediplex of Mass.v. Shalala, 39 F. Supp. 2d 88 (D. Mass. 1999). In 2000, the Supreme Court closed all such loopholes and held that *any* claim arising under the Medicare statute must at least be "presented to" the agency's administrative review process before resort to federal court. Shalala v. Ill. Council on Long Term Care, Inc., 529 U.S. 1 (2000). Since that time, federal courts almost uniformly have held that they do not have jurisdiction to address the merits of CMS enforcement actions before the administrative process is complete. *See*, *e.g.*, Cathedral Rock of N. Coll. Hill, Inc. v. Shalala, 223 F.3d 354 (6th Cir. 2000). As discussed in the text, the "channeling" rule, combined with lengthy delays in the administrative process, makes it difficult to get relief from termination actions and large civil money penalties.

25. *See* Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc., 467 U.S. 837 (1984). In general, under *Chevron*, an agency may "interpret" its regulations only where the plain language of the regulation is ambiguous, the interpretation is within the scope of the agency's expertise, and the authority delegated by Congress. Over the years, some courts have expanded this notion of "deference" to application of agency regulations—whether ambiguous or not—in specific cases, a result that is controversial today.

26. 5 U.S.C. § 500 et seq. (2000).

agency accountability as the number, size, and authority of agencies grew during the New Deal and World War II. All shared the concern that there was no practical way for Congress to provide detailed oversight of the day-to-day activities of the myriad agencies Congress had created to implement various regulatory, economic, and social welfare programs. Thus, as the Supreme Court has put it, Congress enacted the APA as "as an antidote to" this lack of accountability.[27] According to one commentator, "administrative law [developed as] the law *controlling* administrative agencies, not the law *produced by* them."[28] Likewise, Justice Felix Frankfurter noted, in a celebrated law review article that foreshadowed and largely prompted enactment of the APA, "how to fit ancient liberties [to administrative agencies] . . . is the special task of administrative law."[29]

The APA thus addresses two main topics: rulemaking and adjudication. First, "rulemaking," the process for enacting (or repealing) regulations under which the agency establishes and imposes requirements or prohibitions.[30] Such procedures include public notice of proposed regulations (or repeals), a clear statement of purpose and statutory basis for same, and an opportunity for public comment. The courts regularly enforce such procedural hurdles as checks on impatient or unrestrained agency or executive branch action[31] and, as we see in contemporary news reports, the APA can thwart executive branch efforts to repeal regulations without employing such procedures.[32]

And second, "adjudication," the process by which an agency enforces its rules or orders in specific cases; or, as in the case of nursing facility enforcement actions, the process by which the regulated party can challenge such actions.[33] This Article addresses the second part of this second topic, that is, the process by which a nursing facility can challenge a CMS finding of noncompliance with the Long Term Care Requirements of Participation,

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27. Renegotiation Bd. v. Bannercraft Corp., 415 U.S. 1, 34 (1974) (Douglas, J., dissenting on other grounds); Wong Yang Sung v. McGrath, 339 U.S. 33 (1950).

28. B. SCHWARTZ, ADMINISTRATIVE LAW §1.1, 4 (1984) (emphasis added).

29. Felix Frankfurter, *Foreword*, 41 COLUM. L. REV. 585, 586 (1941).

30. 5 U.S.C. § 553 (1966).

31. *See*, *e.g.*, Motor Vehicle Mfrs. Ass'n. of U.S. v. State Farm Mut. Ins., 463 U.S. 29 (1983).

32. *See*, *e.g.*, Lorelei Laird, *Political Lawsuits Bring the Administrative Procedure Act to the Forefront*, ABA J. (Mar. 5, 2018), http://www.abajournal.com/news/article/political_lawsuits_bring_the_administrative_procedure_act_to_the_forefront; Reinventing Governance, *Trump Faces Major Hurdle for Rescinding Rule Under the Administrative Procedure Act*, REINVENTING GOVERNANCE (Feb. 01, 2018), https://fednews.iwpnews.com/trump-faces-major-hurdles-rescinding-rules-under-administrative-procedure-act.

33. 5 U.S.C §§ 554 (1978), 556 (1990), 557 (1976), 558 (1966).

and the resulting sanction; how far that process has drifted from the requirements of the APA, and what can be done to get the process back on track.

This paper applies general administrative law principles in this narrow context. For instance, where does the APA draw the line between facilitation of effective agency action and a regulated party's right to due process? Does the APA allow an agency to develop or implement a review system that allows a non-ALJ to overrule an ALJ's findings of fact or conclusions of law that the ALJ made following an "on the record" proceeding? If so, has the APA failed? And if courts defer to that sort of agency administrative review, has the agency become an unaccountable (and extra-constitutional) fourth branch of government?

Again, the context of these issues is critical. In a perfect world, an agency enforcing health and safety requirements would prevail on the merits in every enforcement case because the regulated party would be on notice of exactly what behavior the regulation requires or prohibits; the agency inspector would carefully document how the party violated that requirement or prohibition; supervisors, or agency counsel, would weed out (or send inspectors back to fix) questionable or weak cases; and the evidence and rationale supporting a violation would be expressed clearly in a charging document, agency pleadings, and the ALJ's Decision.

Unfortunately, those ideal steps do not always happen in CMS nursing facility cases. Surveyors sometimes make up and employ ad hoc standards not set forth in regulations or CMS guidance; emotional reactions to negative resident outcomes sometimes overcome reasoned analysis and application of regulations; poorly trained or inexperienced surveyors sometimes render judgments beyond the scope of their expertise; supervisors sometimes are reluctant to counter the decisions of low level officials (sometimes from fear of appearing "soft" on violators); ALJs sometimes rubber-stamp agency decisions on the basis of "presumptions" of noncompliance; and the agency frequently limits the scope of administrative review.

This Article examines these issues through the lens of the Department of Health and Human Services' ("DHHS") "Departmental Appeals Board" ("DAB" or "Board"), the administrative board that nursing facilities dissatisfied with adverse findings and sanctions must appeal to before heading to court. The premise of the article is that legislative and internal oversight of this sort of nuts-and-bolts agency enforcement decision making largely has failed. Thus, if there is to be any accountability in the system at all, the agency itself must impose internal discipline, largely structured by the APA, lest courts eventually impose such discipline from outside, on an ad

hoc basis, sometimes in cases that present extreme fact patterns, and without necessarily considering all of the agency's legitimate prerogatives.

III. THE ENFORCEMENT AND APPEALS PROCESS

As noted, there are about 15,600 nursing facilities in the country (providing care to about 1.35 million residents), nearly all of which "participate" in the Medicare and Medicaid Programs. In order to obtain and maintain such "certification," a facility must comply with the "Long Term Care Requirements of Participation" set forth in 42 C.F.R. Part 483. Those provisions establish hundreds of specific clinical, resident rights, operational and other requirements.[34]

CMS evaluates compliance with the Long Term Care Requirements of Participation via unannounced annual and "complaint" surveys, usually conducted by a "State Survey Agency" ("SSA"), typically a State Health Department, that acts under contract as CMS' agent.[35] CMS publishes various manuals in which it describes in great detail both the substance of the regulations and its survey procedures. These include the "State Operations Manual," a multi-thousand page tome in which CMS describes some five hundred "tags," or breakdowns, of the regulations.[36] In the State Operations Manual, CMS also provides instructions to surveyors regarding how a facility can meet, or fail to meet, the requirement; the sorts of document reviews and interviews surveyors must conduct (sometimes down to the script); and how to evaluate the seriousness of any noncompliance.

A facility must remain in "substantial compliance" with the Long Term Care Requirements of Participation, which is defined by regulation as "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm."[37] This provision must be read in conjunction with various provisions of the State Operations Manual under which

34. States also impose and enforce their own regulatory requirements, typically via licensure requirements, most of which are similar, or even identical, to the federal certification requirements. Some, but not all, states impose parallel licensure sanctions, and state appeals processes vary considerably. Again, this Article addresses only the federal appeals process.

35. 42 U.S.C. § 1395aa(a) (2008). CMS also conducts some surveys directly, usually to "look behind" the SSA's performance, but the general process is the same.

36. The "State Operations Manual" is an online-only manual that CMS updates on an ongoing basis. *See generally* CTR. FOR MEDICARE & MEDICAID SERVS., PUB. NO. 100-07, STATE OPERATIONS MANUAL, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1201984.

37. 42 C.F.R. §§ 488.300 (1994), 488.330 (2011).

surveyors assign a score to each cited "deficiency" from a table that describes four levels of "severity" (potential for minimal harm, potential for more than minimal harm, actual harm, and "immediate jeopardy' to resident health and safety), and three levels of "scope" (isolated, pattern, widespread). CMS' enforcement regulation then assigns sanctions, for instance, the amount of a CMP, based upon a finding of noncompliance, and this score.[38]

Surveyors are typically Registered Nurses, or professionals from other pertinent disciplines, who are qualified to perform surveys by experience, and by passing a CMS training course.[39] In practice, CMS allows surveyors to exercise "judgment" about how to interpret and apply both the regulations and CMS' Interpretive Guidelines to the regulations. For instance, CMS manuals describe hundreds of examples of potentially inappropriate uses of medications, and CMS allows surveyors to second-guess physician orders for such medications.[40] If the SSA finds noncompliance—and more than 90% of nursing facilities are cited for some degree of noncompliance annually[41]—it documents its "findings"—that is, its allegations of noncompliance—in a written "Statement of Deficiencies." The facility then must submit and implement a written "Plan of Correction."[42] The regulations also require each State to provide facilities with a process for an "informal dispute resolution" of citations with which they disagree.[43] Those processes vary considerably

38. *See* 42 C.F.R. §§ 488.404(b) (1994), 488.438 (2016). (A surveyor can cite noncompliance that does not "have the potential for more than minimal harm"—the lowest score on CMS' 'severity" and "scope" grid—which does not support imposition of any sanction.).

39. The CMS training course consists of various "modules," and so, for instance, a social worker might pass the "nursing" module, and thus be "qualified" to evaluate and cite noncompliance regarding complicated clinical issues, which can be the basis for disputes and appeals. *See* STATE OPERATIONS MANUAL, *supra* note 37, at §§ 4009 et seq.

40. In a typical recent decision, the Board imposed a civil money penalty in excess of $1.4 million against a nursing facility where a nurse surveyor disagreed with an order a resident's physician – who was not even a facility employee—had given limiting anesthesia for oral surgery that had resulted in the surgery being delayed. Putnam Ctr. v. CMS, DAB No. 2850 (2018). Board and ALJ decisions are reported on the Board's website, https://www.hhs.gov/about/agencies/dab/index.html.

41. *See* DHHS OFFICE INSPECTOR GEN., TRENDS IN NURSING HOME DEFICIENCIES AND COMPLAINTS, OIG REPORT NO. OEI-02-08-00140 (September 18, 2008), https://oig.hhs.gov/oei/reports/oei-02-08-00140.pdf. The overall trends in recent years have been similar, although the average number of deficiencies per facility varies considerably from state to state, a result the OIG and the Government Accountability Office have criticized for many years.

42. 42 C.F.R. §§ 488.300(a) (1994); (a)(1)(D) (1994); 488.408(f) (2016).

43. 42 C.F.R. § 488.331 (2011).

from state to state, from internal rubber-stamps, to informal hearings after which hearing officers may set aside inappropriate citations.

The Social Security Act and CMS' "Enforcement Regulations" then set forth an "enforcement" system that authorizes CMS to impose sanctions (known as "remedies") for noncompliance, including civil money penalties ("CMPs") as high as $20,628 per day of noncompliance (which can total millions of dollars);[44] denials of payment for new Medicare/Medicaid admissions (which can starve a facility);[45] temporary third-party management;[46] state monitoring;[47] directed plans of correction;[48] directed training;[49]and ultimately, "termination" from the Medicare and Medicaid Programs (which usually operates as a regulatory death sentence).[50] As noted above, CMS manuals set forth an elaborate system of classifying violations by "severity" and "scope," and for matching various categories of violations to specific remedies, although the regulations also accord CMS considerable discretion regarding imposition of remedies.[51] In most cases, the SSA recommends, and CMS imposes, the remedy. Sometimes, a "Plan of Correction" and SSA "revisit" to assure compliance is all that CMS requires to address and correct relatively minor deficiencies. However, at the other extreme, in about 2% of cases, CMS imposes enhanced CMPs running into the millions of dollars for violations that pose "immediate jeopardy" to

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44. 42 U.S.C. § 1395i-3(h) (2014); 42 C.F.R. §§ 488.430 et seq. (2011). The same statutory provision authorizes all of the remedies discussed in the text. Note that 42 C.F.R. § 488.436(b) provides for an automatic reduction of the CMP of 35% if the facility waives an appeal; in effect, this provision puts a 35% penalty on choosing to appeal and gives CMS a 35% cushion when negotiating settlement. (The regulation also provides for a 50% reduction in certain circumstances where a facility self-reports a serious violation, but that provision is employed very rarely.).

45. 42 C.F.R. § 488.417 (1995).

46. 42 C.F.R. § 488.415 (1994).

47. 42 C.F.R. § 488.422 (1995).

48. 42 C.F.R. § 488.424 (1994).

49. 42 C.F.R. § 488.425 (1995).

50. 42 C.F.R. § 488.456 (1994).

51. 42 C.F.R. § 488.408 (2016). Subsection 408(g)(2) specifically provides that a facility may not appeal the "choice of remedy." Remedies actually are imposed by CMS' ten Regional Offices, whose philosophies and practices differ considerably. For instance, some Regional Office officials impose very large CMPs, while others believe that CMPs take resources from resident care, and so focus on, say, directed plans of correction. Over the years, the DHHS Office of Inspector General and the Government Accountability Office have issued numerous reports critical of this inconsistency, which persists, and vividly illustrates the difficulty of imposing procedural limits even *inside* an agency.

resident health and safety, defined as noncompliance that "has caused or is likely to cause, serious injury, harm, impairment, or death to a resident."[52]

The Social Security Act provides that where CMS makes an adverse finding, a facility is entitled to an evidentiary hearing before a neutral administrative law judge to challenge the factual and legal bases for the sanction.[53] In 1994, CMS adopted regulations at 42 C.F.R. Part 498 that provide for a trial-type adjudication before an Administrative Law Judge ("ALJ") of what is now called the "Departmental Appeals Board" ("DAB" or "Board"), to effectuate that right. At any given time, there are about half a dozen ALJs who hear appeals in nursing facility cases (as well as appeals of many other DHHS actions).[54]

Many courts have held that because Congress provided no express exemption from the APA, the usual APA standards govern these Part 498 proceedings.[55] The most basic "adjudication" rule under the APA is that the "proponent of an order," in this case, CMS, has the burden of proof to sustain the order throughout a proceeding contesting the order.[56] Thus, in their earliest cases under Part 498, the Secretary's ALJs and the courts recognized that CMS had the burden under Part 498 to come forward with evidence to support any factual allegations (or, as CMS calls them, "findings") that CMS identified as the "basis" for a sanction. The Secretary's ALJs and the courts also recognized that if the agency failed to do so, then the petitioner prevailed "even if it offers no evidence at all."[57] If CMS established a "prima facie case" of noncompliance (which no regulation defines, but which the Board

52. 42 C.F.R. § 488.301 (2017).

53. 42 U.S.C. § 1395i-3(h)(2)(B)(ii) (2014) (incorporating by reference 42 U.S.C. § 1320a-7a).

54. *See* Dep't Appeals Bd. (DAB), *Who Are the Board Members & Judges?*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (Aug. 10, 2018), https://www.hhs.gov/about/agencies/dab.

55. *See*, *e.g.*, Sunshine Haven Nursing Operations, LLC v. Dept. of Health and Human Serv., 742 F.3d 1239 (10th Cir. 2014); Friedman v. Sebelius, 686 F.3d 813 (D.C. Cir. 2012); Grace Healthcare of Benton v. Dept. of Health & Human Servs., 589 F.3d 926 (8th Cir. 2009); Liberty Commons—Johnston v. Leavitt, 241 Fed. Appx. 76 (4th Cir. 2007); Beechwood Restorative Care Ctr. v. Thompson, 494 F. Supp. 2d 181 (W.D.N.Y. 2007). *See* Dickinson v. Zurko, 527 U.S. 150 (1999) (APA intended to provide uniform standard of review for agency actions; Congress contemplated no judicial "rubber stamp" of such actions); W. Va. Dep't of Health v. Sebelius, 649 F.3d 217 (4th Cir. 2011) (applying Section 706(2)(A) to review Board decision); S.C. Health & Human Servs. Finance Comm'n v. Sullivan, 915 F.2d 129 (4th Cir. 1990) (applying Sec. 706(2)(A) standard following hearing by comparable DHHS appeals board).

56. 5 U.S.C. § 556(d) (1990); Steadman v. SEC, 450 U.S. 91 (1981); Universal Camera Corp. v. NLRB, 340 U.S. 474 (1951).

57. Hillman Rehab. Ctr. v. HCFA, DAB No. 1611 (1997), *aff'd*, No. 98-3789 (D. N.J. 1999).

basically says means allegations, which, if true, could support a finding of noncompliance[58]), the burden then shifted to the petitioner to demonstrate compliance with the regulation in question, typically by showing that its staff's actions met applicable standards of care, or by an affirmative defense (typically that a resident had refused care) or that an adverse outcome was clinically unavoidable (for instance, the natural progression of a disease process). These principles became known as the "*Hillman* rule," after the case in which the Board first described them.

As outlined below, the Board has no generally applicable procedural rules (other than for ministerial matters such as numbering of exhibits and the like), so the ALJs establish their own hearing procedures.[59] For example, some ALJs require submission of "written direct testimony" before the hearing, while others prefer to hear witnesses testify live. Hearings can take anywhere from a few hours to several days, again, depending on an individual ALJ's preferences. Hearsay is admissible, but different ALJs accord different weight to such evidence. In recent years, budget restrictions have required ALJs to conduct hearings by videoconference (in the past the ALJ would travel to a location near the appealing facility). The Board also has limited the number of hearings, causing a significant backlog, also because of budget issues. Thus, the number of ALJ and Board Decisions on the merits in nursing facility appeals has dropped dramatically from fifty or more per year to only a handful today, about half of which ALJs now decide by "summary judgment" in favor of CMS (that is, without a hearing).[60]

Following the hearing (or summary judgment motion), an ALJ must issue a written decision,[61] and the losing party can request review by a three-member panel of the Board.[62] The Board rarely entertains even oral argument, almost always upholds CMS sanctions, and almost always reverses every ALJ Decision in favor of a facility.[63]

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58. For instance, the Board sometimes holds that the allegations in a Statement of Deficiencies, *without more*, are sufficient to establish CMS' "prima facie case," and to shift the burden of demonstrating compliance to the petitioner. *See* Southpark Meadows Nursing & Rehab. Ctr. v. CMS, DAB No. 2703 (2016).

59. The Board's general rules are at 42 C.F.R. pt. 498 (2008).

60. Board and ALJ decisions are available on the Board's website, https://www.hhs.gov/about/agencies/dab/index.html, and some are reported by commercial services.

61. 42 C.F.R. § 498.74 (1996).

62. 42 C.F.R. § 498.80 (1996).

63. The author has tracked all ALJ. and Board decisions for about twenty years. Before 2010, nursing facilities won about one-third of ALJ decisions on the merits, and CMS rarely appealed adverse decisions to the Board. Since 2010—when the Board changed its review

Judicial review of Board Decisions is bifurcated: appeals of CMPs go directly to the Court of Appeals and appeals of other sanctions to the District Court.[64] The courts apply the traditional review standard of Section 706(2)(A) of the APA, that is, the agency action will be set aside if "arbitrary, capricious, or otherwise not in accordance with law."[65] 42 U.S.C. § 1320a-7a, which governs appeals of civil monetary penalties, also provides that the standard of review of the Board's findings of fact following an evidentiary hearing is "substantial evidence in the record, taken as a whole."

IV. THE BOARD'S CURRENT APPLICATION OF THESE STANDARDS

In recent years, the Board's administrative review process has rejected virtually every aspect of the APA and has taken on a life of its own. The Board largely has abandoned the *Hillman* rule described above, and now says that it is *not* bound by APA standards, even though Congress has provided no such exemption. The background for this rejection is murky, as neither the Secretary of Health and Human Services, nor the Board, has ever explained it in any official statement.

For instance, the Board has held in a series of cases over the past ten years that it now considers all of the allegations in a "Statement of Deficiencies"—including those a petitioner contests—to be "presumptively correct," and that a petitioner bears the burden throughout the proceeding somehow to

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standard, discussed in the text—the number of ALJ decisions that completely set aside all deficiencies and remedies has declined to only a handful a year, and during that time the Board has reversed *every* ALJ decision in favor of a facility that CMS has appealed.

64. 42 U.S.C. § 1320a-7a (2018); 42 C.F.R. § 498.90 (1996).

65. *See, e.g.*, Sunshine Haven Nursing Operations, LLC v. Dep't of Health & Human Servs., 742 F.3d 1239 (10th Cir. 2014); Friedman v. Sebelius, 686 F.3d 813 (D.C. Cir. 2012); Grace Healthcare of Benton v. Dep't of Health & Human Servs., 589 F.3d 926 (8th Cir. 2009); Liberty Commons—Johnston v. Leavitt, 241 Fed. Appx. 76 (4th Cir. 2007). *See* Dickinson v. Zurko, 527 U.S. 150 (1999) (APA intended to provide uniform standard of review for agency actions; Congress contemplated no judicial "rubber stamp" of such actions); W. Va. Dep't of Health v. Sebelius, 649 F.3d 217 (4th Cir. 2011) (applying Sec. 706(2)(A) to review Board decision); S.C. Health & Human Servs. Finance Comm'n v. Sullivan, 915 F.2d 129 (4th Cir. 1990) (applying Section 706(2)(A) standard following hearing by comparable DHHS appeals board).

"persuade" the Board otherwise.[66] This position would seem directly to conflict with Section 556(d) of the APA.[67]

The Board also has stated that it considers ALJ and Board review to be "de novo," and that it is not "restricted to the facts and evidence that were available to CMS when it made its decision," nor "how or why CMS decided to impose remedies," nor even the record developed in the Part 498 hearing. According to the Board's latest cases, it says it views the Part 498 review process *not* to provide petitioners *independent* review of agency actions, but only to provide an opportunity for the Board to act as "the final step in the enforcement process," and even to "fix" flawed CMS or ALJ determinations.[68] Thus, the Board now specifically holds that its review of ALJ decisions is *not* comparable to the independent "oversight role of a federal court in reviewing agency decisions to determine if an adequate basis is articulated."[69] Not incidentally, following its abandonment of the *Hillman* rule, the Board has reversed *every* ALJ Decision in favor of a nursing facility that CMS has appealed to it.[70] No court has directly addressed most aspects of the Board's movement away from APA standards—at least not yet.[71]

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66. *See, e.g.*, Southgate Meadows Nursing & Rehab. Ctr. v. CMS, DAB No. 2703 (2016); St. Joseph Villa v. CMS, DAB No. 2210 (2008) (reversing summary judgment for a petitioner where CMS relied only on the Statement of Deficiencies and offered no supporting evidence); Barbourville Nursing Home v. CMS, DAB No. 1962 (2005).

67. In a typical description of the Board's current iteration of the parties' respective burdens, the Board will uphold CMS sanctions where a petitioner does not "demonstrate that the ALJ's findings were *not* based on substantial evidence." Plott Nursing Home v. CMS, DAB No. 2426 (2011) (emphasis added).

68. As a result, the Board frequently constructs "post hoc rationalizations" for CMS sanctions—that is, articulates a different basis for a sanction than the agency itself stated (and the petitioner challenged—exactly what the Supreme Court held the APA prohibits in Citizens to Pres. Overton Park, Inc. v. Volpe, 401 U.S. 402 (1970). In the few cases that address this point, the Board says that *Overton Park* applies only to judicial review, not its review.

69. Golden Living Ctr.—Riverchase v. CMS, DAB No. 2314 (2010); Beatrice St. Dev. Ctr. v. CMS, DAB No. 2311 (2010); Britthaven of Chapel Hill v. CMS, DAB No. 2284 (2009); Cal Turner Extended Care Pavilion v. CMS, DAB No. 2030 (2006).

70. The Board does occasionally reverse an ALJ summary judgment in favor of CMS where the petitioner shows that the ALJ did not address and resolve material factual disputes (while Fed. R. Civ. P. 56 does not directly apply to Board proceedings, the Board does say that it applies Rule 56 principles to summary judgment motions).

71. The court in Plott Nursing Home v. Burwell, 779 F.2d 975, 985-89 (9th Cir. 2015), held that because unaddressed citations of noncompliance can and do have continuing enforcement consequences (for instance, CMS can and does rely on a facility's enforcement history when choosing sanctions), an ALJ cannot decline to review every deficiency that a petitioner contests simply because he or she states that he or she could sustain the sanction on the basis of a subset of all the citations. The Board rejects this analysis, and applies it, if at all,

In fact, as discussed immediately below, the Secretary of Health and Human Services has long tried to limit review of CMS enforcement decisions, and the Board usually has accommodated that effort, beginning with the threshold issue of what enforcement determinations are appealable. One recent development has accelerated that effort. Until recently CMS was authorized to collect CMPs only *after* the conclusion of an appeal,[72] but in 2010, as part of the Affordable Care Act ("ACA"), Congress authorized CMS to adopt regulations that "may" provide for collection or "escrow" of CMPs *pending* appeals.[73] In 2012 CMS proposed a draft regulation, now codified at 42 C.F.R. § 488.431(b), to implement this ACA provision. CMS explained its rationale for the regulation in a lengthy official comment in which it noted a series of reports by the Government Accountability Office and the DHHS Inspector General that expressed concerns about "delays in payment of a civil money penalty" (in fact, the cited reports actually critiqued delays *by CMS* in processing survey documents and collecting CMPs *after* the completion of appeals). But CMS also recited that *the agency's* goal was "to eliminate a facility's ability to significantly defer the direct financial effect of an applicable CMP until after an often long litigation process," which CMS specifically derided as a distraction from its enforcement prerogatives.[74]

CMS' rationale for this rule is curious at best, for the Supreme Court has held that the government may *seize money or property* prior to a hearing in non-criminal cases only in "extraordinary situations where some valid governmental interest is at stake that justifies postponing the hearing until after the event."[75] Nevertheless, CMS dismissed commenters' concerns about the due process implications of seizing CMPs without prior administrative

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only to cases originating in states that comprise the Ninth Circuit. Similarly, as noted below, a District Court in Nebraska ordered the Board to hold a hearing in a case in which CMS had withdrawn a remedy and argued that the case therefore did not trigger the right to a Part 498 hearing. Again, the Board disagrees, and has refused to schedule the hearing the court ordered. Golden Living Ctr.—Grand Island Lakeview v. CMS, No. 8:11CV119 (D. Neb. Dec. 16, 2011) (reversing DAB No. 2364 (2011).

72. 42 U.S.C. § 1395i-3(h)(5) (2010) formerly provided that only denials of payment and temporary managers "may be imposed during the pendency of any hearing;"42 C.F.R. §§ 488.440(b) (2012), 488.442(a)(1) (2011), read together, formerly provided that civil monetary penalties were payable fifteen days after a "final administrative decision" regarding a CMP. The Affordable Care Act amended Sec. 1395i-3(h)(5) to add authority to collect CMPs during pendency of the hearing.

73. Sec. 6111(a)(1) of the Affordable Care Act, codified at 42 U.S.C. § 1395i-3(h)(2)(b)(ii)(IV) (2014).

74. Medicare and Medicaid Programs; Civil Money Penalties for Nursing Homes, 76 Fed. Reg. 15106 (Mar. 18, 2011) (to be codified at 42 C.F.R. pt. 488).

75. United States v. James Daniel Good Real Prop., 510 U.S. 43 (1993).

or judicial review, stating in its Official Comment that it would create a new "independent informal dispute resolution process" ("IIDR"), in which sanctioned parties could dispute deficiencies *prior to,* or *as an alternative to* the appeal process. Congress thus provided IIDR as a due process counterweight to escrow—the provisions are in the same statutory section—but CMS routinely disregards or rejects IIDR recommendations in favor of facilities.

The agency's efforts to limit challenges to its enforcement decisions also has been baked into its regulations. The administrative and judicial review provisions of the Social Security Act appear, on their face, to allow challenges to *any* enforcement determination or decision by the Secretary of Health and Human Services.[76] But CMS' appeal regulations, and the Board's interpretation and application of those regulations, erect significant *substantive* limits on administrative appeals.[77]

Most importantly, the Secretary has implemented regulations that appear to contradict the plain language of the statute that allows appeals of all Secretarial adverse actions. 42 C.F.R. § 498.3 provides, the Board consistently holds, that a facility may appeal only certain "initial determinations," which the Board defines to mean a finding of noncompliance *that results in the imposition of any enforcement remedy*, but *not* the underlying deficiency itself if CMS imposes no remedy.[78] Thus, there is no right to appeal an adverse informal dispute resolution decision;[79] or an SSA or CMS rejection of a Plan of Correction (even if that result leads to termination, which would be appealable);[80] or an SSA recommendation of a sanction.[81]

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76. 42 U.S.C. §§ 405(e), (g) and (h) (2018); 42 U.S.C. § 1395i-3(h)(2)(B)(ii) (2014) (incorporating 42 U.S.C. § 1320a-7a).

77. 42 C.F.R. § 498 (2008) (especially 42 C.F.R. § 498.3(2012)).

78. The Secretary argued in her briefs and oral argument in Shalala v. Ill. Council on Long Term Care, Inc., 529 U.S. 1 (2000), that deficiencies *could* be appealed one way or another (for instance, by accepting a small civil monetary penalty), and the Court specifically referred to that representation in requiring that all such challenges must be "channeled" through the Board. A federal district court suggested in Golden Living Ctr.—Grand Island Lakeview v. CMS, No. 8:11CV119 (D. Neb. Dec. 16, 2011) (reversing DAB No. 2364 (2011), which found that if the Board declines to conduct *any* review of an enforcement determination, then a court might accept such an appeal on the merits in the first instance.). But the Board rejects that analysis and has disregarded the Court's Order (seven years later the Board has not reassigned the case to an ALJ).

79. 42 C.F.R. § 488.331 (2011); *see, e.g.*, Cap. Home Nursing and Rehab. Ctr. v. CMS, DAB No. 2252 (June 10, 2009).

80. Great Lakes Healthcare v. CMS, A.L.J. Ruling No. 2016-14, 1-2 (July 25, 2016).

81. *See* Glenoaks Convalescent Hosp. v. CMS, A.L.J Ruling No. CR4805, 1-3 (March 7, 2017), https://www.hhs.gov/sites/default/files/alj-cr4805.pdf; Bruceville Terrace v. CMS,

The Board also interprets Section 498.3 to mean that facilities may appeal only remedies *that persist through the appeal*, and not the *imposition* of the remedy itself. Thus, if CMS imposes but then withdraws a remedy, even during the course of an otherwise properly perfected appeal (typically because CMS fears it might lose on the merits), the Board will dismiss the appeal. The Board consistently holds that the facility's right to appeal even an egregiously wrong violation is thereby vitiated, and so the citation remains on the facility's public record.[82]

The Board has also held that, notwithstanding the statutory language that *any* "affected party" may contest an adverse enforcement determination, only *active* Medicare providers may initiate appeals of enforcement determinations, even if the facility nevertheless is "affected by" the determination. Thus, the Board has held that a *Medicaid-only* facility may not appeal termination of its Medicaid Provider Agreement (unless CMS itself terminated the Agreement).[83] Likewise, the Board has held that a Medicare certified facility that for some reason has an inactive Medicare Provider number may not appeal an enforcement action.[84] The Board recently dismissed an appeal because the party filing the appeal could not

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A.L.J. Ruling No. 2016-8, at 1-2 (Feb. 1, 2016), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2016/alj2016-8.pdf.

82. There are dozens of cases illustrating this point. *See, e.g.*, Fountain Lake Health & Rehab. Ctr. v, CMS, DAB Dec. No. 1985 (July 6, 2005), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2005/dab1985.htm; Arcadia Acres, Inc. v. HCFA, DAB Dec. No. 1607 (Jan. 20, 1997), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/1997/dab1607.html; Sunset Villa v. CMS, ALJ Dec. No. CR1683 (Nov. 2, 2007), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2007/cr1683.pdf; Gulf Pointe Specialty Hosp. v. CMS, ALJ Dec. No. CR1651 (Sep. 17, 2007), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2007/cr1651.pdf; Grace Care Ctr. v. CMS, ALJ Dec. No. CR1647 (Sep. 14, 2007), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2007/cr1647.pdf; Colonial Oaks Guest Care Ctr. v. CMS, ALJ Dec. No. CR1618 (June 29, 2007), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2007/cr1618.pdf; Corpus Christi Nursing & Rehab. V. CMS, ALJ Dec. No. CR1616 (June 26, 2007), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2007/cr1616.pdf; Twin Pines Nursing & Rehab. Ctr. v. CMS, ALJ Dec. No. CR1601 (May 25, 2007), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2007/cr1601.pdf; Heritage Manor of Franklinton v. HCFA, ALJ Dec. No. CR666 (May 2, 2000), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2000/cr666.html.

83. Bryn Mawr Care v. CMS, ALJ Dec. No. CR2277, 1-2 (Nov. 1, 2010), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2010/cr2277.pdf.

84. Guild Home for the Aged Blind v. CMS, ALJ Dec. No. CR2437, 1-2, 5-7, 9 (Sep. 26, 2011), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2011/cr2437.pdf.

show that it actually controlled the facility at the time it initiated the appeal.[85] CMS once successfully persuaded a Court of Appeals to dismiss an appeal of a CMP where a successor operator paid the penalty, even though the petitioner would have received a refund had it prevailed.[86]

The Board also consistently holds that ALJs have very limited authority. The Board says that ALJs do not have the authority to enter stays or injunctions,[87] to review whether a regulation is consistent with the governing statute,[88] to review CMS' choice of remedy (e.g., an ALJ cannot decide that a deficiency exists but warrants only a CMP and not termination),[89] to review IDR determinations,[90] to review claims of bias,[91] to review constitutional claims,[92] or to review CMS' failure to promulgate its survey and enforcement policies via the "notice and comment" provisions of the APA.[93] In a recent case, an ALJ set aside a survey finding on the ground that the survey team did not include a registered nurse, which the statute and regulations specifically require; the Board reversed that Decision on the ground that an ALJ may not

85. Sunview Care & Rehab Ctr. LLC, DAB Dec. No. 2713, 1 (June 15, 2016), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2016/dab2713.pdf.

86. Jennifer Matthew Nursing & Rehab. Ctr. v. DHHS, 607 F.3d 951 (2d Cir. 2010).

87. *See*, *e.g.*, Palm Grove Convalescent Ctr. v. HCFA, ALJ Docket No. C-99-12 (1999) (unreported).

88. *See*, Dir. of the Office for Civil Rights v. Univ. of Tex. MD Anderson Cancer Ctr., ALJ Dec. No. CR5111, 3 (June 1, 2018), https://www.hhs.gov/sites/default/files/alj-cr5111.pdf.

89. *See*, *e.g.*, Beverly Health & Rehab. Ctr. v. HCFA, DAB Dec. No. 1696 (July 1, 1999), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/1999/dab1696.htm; Aase Haugen Homes, Inc. v. CMS, ALJ Dec. No. CR1273 (Jan. 31, 2005), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2005/CR1273.htm.

90. Rutland Nursing Home v. CMS, ALJ Ruling 2014-12, 5 (November 8, 2013), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2013/alj2014-12.pdf.

91. Jewish Home of E. Pa. v. CMS, ALJ Dec. No. CR2421, 5-6 (Aug. 30, 2011), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2011/cr2421.pdf.

92. Carrington Place of Muscatine v. CMS, DAB Dec. No. 2321, 23-24 (June 25, 2010), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2010/dab2321.pdf.

93. *See*, *e.g.*, Orchard Grove Extended Care Ctr. v. HCFA, ALJ Dec. No. CR541, 3, 5 (July 20, 1998), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/1998/cr541.PDF; Green Oaks Hosp. v. CMS, ALJ Dec. No. CR861 (Jan. 28, 2002), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2002/cr861.html.

consider violations of the survey process where there are otherwise appropriate citations.[94]

The Board does permit appeals that challenge only the duration of noncompliance (and thus the duration of a "per diem" CMP). In other words, a petitioner can concede noncompliance but offer evidence and argument that it resumed compliance on an earlier date than CMS says, and so the per diem penalty likewise should end sooner than CMS found.[95] It also theoretically possible for a petitioner to concede noncompliance but argue that any deficiency did not pose the risk of more than minimal harm and thus cannot support a sanction.[96]

While not strictly an APA issue, the Board's regulations require that a nursing facility must file its "Request for Hearing" within 60 calendar days after *receipt* of the CMS Notice imposing a remedy—not within 60 days after the *effective date* of the remedy.[97] This can be very problematic where a facility receives a Notice imposing a remedy that will become effective at a future date if the facility does not correct a deficiency and resume compliance before that date, because the Board says that the 60 days runs from the receipt of the Notice even in such a case (when the appeal may wind up being moot). There are dozens of decisions dismissing appeals where the facility misses this deadline *by even one day*.[98] While the regulation does provide that the Board may extend this deadline upon a showing of "good cause"—the Board has held that CMS does not have such authority[99]—the Board has conceded that it never has defined "good cause," and there never has been a case where an ALJ or the Board has found that any circumstance constitutes "good cause" for extending the filing deadline.[100]

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94. Avon Nursing Home v. CMS, DAB Dec. No. 2830, 10-11 (Nov. 6, 2017), https://www.hhs.gov/sites/default/files/board-dab-2830.pdf, *rev'g* Dallas Home Health Care, Inc. v. CMS, ALJ Dec. 4760 (Dec. 13, 2016), https://www.hhs.gov/sites/default/files/alj-cr4760.pdf.

95. *See*, *e.g.*, Libertyville Manor Rehab. & Health Care Ctr. v. CMS, DAB Dec. No. 2849 (Feb. 7, 2018), https://www.hhs.gov/sites/default/files/board-dab-2849.pdf.

96. 42 C.F.R. §§ 488.404(b), 488.438; *supra* n. 38.

97. 42 C.F.R. § 498.40(a)(2).

98. Knox County Nursing Home v. CMS, ALJ Dec. No. CR1588, 3 (Apr. 19, 2007), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2007/cr1588.pdf (two days late).

99. West Side House LTC Facility v. CMS, DAB Dec. No. 2791, 7 (May 18, 2017), https://www.hhs.gov/sites/default/files/board-dab-2791.pdf.

100. Brookside Rehab. & Care Ctr. v. CMS, DAB Dec. No. 2094 (June 27, 2007), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2007/dab2094.pdf. Some fact patterns illustrate fairly extreme circumstances, such as the case of a physician whose Medicare exclusion appeal was dismissed notwithstanding his

Whether a particular set of facts constitutes noncompliance is a mixed question of fact and law: whether the agency's allegations are accurate and complete, and whether the regulatory provision reaches the alleged act or omission. However, the Board resists the notion that the legal part of the analysis consists of "elements" similar to civil or criminal claims.[101] Likewise, the Board allows ALJs to *infer* more general violations, for instance, "neglect," "inadequate administration," or failure of "quality assurance," solely from a violation of a more specific requirement.[102]

The Board also allows an ALJ to grant summary disposition *in favor of CMS* without stating that he or she even considered a petitioner's evidence.[103] The Board recites that the familiar standard of Federal Rule of Civil Procedure 56 "guides" its consideration of summary judgment motions[104]—

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argument that he never received the applicable notice because he was in jail; the Board held that he did not overcome the "presumption" that he received the notice three days after it was mailed. Kenneth Schrager, DAB Dec. No. 2366, 1-2, 5 (May 15, 2011), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2011/dab2366.pdf. For what it is worth, attorney error (divorce, etc.) is not "good cause." Heritage Park Rehab. & Nursing Ctr. v. CMS, ALJ Dec. No. CR2028, 4 (Nov. 12, 2009), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2009/CR2028.pdf. *See also* Ada Care Ctr. v. CMS, ALJ Ruling 2014-10 (Nov. 4, 2010), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2013/alj2014-10.pdf; Parkside Surgery Inst. V. CMS, ALJ Dec. No. CR2319 (Feb. 9, 2011), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2011/cr2319.pdf.

101. Thus, for instance, the Board says that it is immaterial if CMS cites the wrong regulatory provision if it can derive any other basis for noncompliance from the record. *See, e.g.*, Avalon Place Trinity v. CMS, DAB Dec. No. 2819 (Sept. 15, 2017), https://www.hhs.gov/sites/default/files/board-dab-2819.pdf; Kindred Transitional Care & Rehab.—Greenfield, DAB Dec. No. 2792 (May 18, 2017), https://www.hhs.gov/sites/default/files/board-dab-2792.pdf.

102. *See, e.g.*, Heritage Place Nursing Ctr. v. CMS, DAB Dec. No. 2829 (Oct. 31, 2017), https://www.hhs.gov/sites/default/files/board-dab-2829.pdf.

103. No ALJ ever has granted summary judgment in favor of a facility. In the past, ALJs regularly ruled that where CMS failed to offer a prima facie case of noncompliance on one or another citation under *Hillman*, the petitioner did not have to defend such citations. Now, while some ALJs entertain the equivalent of a Motion for Directed Verdict at the conclusion of CMS' case, even those who do so will reserve decision, usually on the ground that 42 C.F.R. § 498.63 provides CMS the right to file a written brief on any citation it alleges. Some ALJs even allow CMS to argue citations for the first time in briefs for which they have offered no evidence—and thus no prima facie case of noncompliance—at the hearing. *See, e.g.*, Donelson Place Care & Rehab. v. CMS, ALJ Dec. No. CR5132 (2018) (sustaining a citation for which CMS offered no evidence).

104. Cedar Lake Nursing Home, DAB Dec. No. 2344, 2 (Nov. 18, 2010), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2010/dab2344.pdf (holding that Rule 56 does *not* govern its proceedings, but only provides "guidance"). There are actually many judicial decisions that recite that administrative

that is, that the party seeking summary judgment must offer evidence regarding every element of the claim in question, the evidence must be construed against the party seeking summary judgment, and all inferences that reasonably can be drawn from the evidence must be resolved *against* the moving party.[105] But the Board actually does *not* follow this rule in practice. For instance, the Board does *not* follow the usual rule courts apply in administrative enforcement cases that an unsworn charging document (the Statement of Deficiencies) is *not* considered to be "evidence" for purposes of Rule 56. This is because granting summary judgment on the basis of such unsworn allegations has the effect of reversing the burdens of production and proof established by the Rule.[106] In fact, ALJs routinely draw inferences for purposes of summary judgment *against* facilities, even where CMS offers nothing beyond the Statement of Deficiencies.[107] There are numerous Decisions in which ALJs reject the opinions of expert affiants, medical journals, and the like, as insufficient to create material issues of fact.[108] The Board does occasionally reverse ALJ Decisions granting summary judgment to CMS,[109] but there is no pattern to such cases, and it also frequently affirms

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agencies that employ summary proceedings *must* follow Rule 56. Crestview Parke Care Ctr. v. Thompson, 373 F.3d 743, 747 (6th Cir. 2004) (DAB case); *see also*, *e.g.*, Puerto Rico Aqueduct & Sewer Auth. v. EPA, 35 F.3d 600, 604-607 (1st Cir. 1994); Veg-Mix, Inc. v. USDA, 832 F.2d 601, 608 (D.C. Cir. 1987); Consol. Oil & Gas, Inc. v. FERC, 806 F.2d 275, 279 (D.C. Cir. 1986). *See generally* CHARLES KOCH, ADMINISTRATIVE LAW AND PRACTICE § 5.42 (2d. ed. 1997).

105. *See* Celotex Corp. v. Catrett, 477 U.S. 317, 322-23 (1986); Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 247-252 (1986); Matsushita Elec. Ind. Co. v. Zenith Radio Corp., 475 U.S. 574, 586-7 (1986).

106. *See*, *e.g.*, United States v. Menendez, 48 F.3d 1401, 1414 (5th Cir. 1995).

107. *See*, *e.g.*, Life Care Ctr. of Merrimack Valley v. CMS, CR4965 (Nov. 6, 2017), https://www.hhs.gov/sites/default/files/alj-cr4965.pdf.

108. *See*, *e.g.*, Senior Rehab. & Skilled Nursing Ctr. v. CMS, DAB Dec. No. 2300, 5 (Jan. 29, 2010), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2010/dab2300.pdf; Oak Ridge Ctr. v. CMS, ALJ Dec. No. CR4865, 6-7 (June 13, 2017), https://www.hhs.gov/sites/default/files/alj-cr4865.pdf.

109. *See*, *e.g.*, NMS Healthcare of Hagerstown v. CMS, DAB Dec. No. 2803, 1 (July 20, 2017), https://www.hhs.gov/sites/default/files/board-dab2803.pdf, *rev'ing* ALJ Dec. No. CR3772 (2015), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2015/cr3772.pdf (notably holding that even if CMS' evidence establishes a prima facie case of noncompliance, that is not sufficient to support summary judgment); Grace Living Ctr.—Nw. OKC v. CMS, DAB Dec. No. 2633, 1 (Apr. 17, 2015), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2015/dab2633.pdf, *rev'ing* ALJ Dec. No. CR3347 (2014), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2014/cr3347.pdf; Hanover Hill Health Care Ctr. v. CMS, DAB Dec. No. 2507 (Apr. 10, 2013), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-

summary disposition even when the petitioner contests the accuracy of CMS' material factual allegations.

If a case does proceed to hearing—perhaps 10% of filed cases do so—CMS at least theoretically bears the initial burden of *proceeding*. That is, the agency must offer evidence regarding each element of each allegation of noncompliance the petitioner disputes in order to establish a "prima facie case" of noncompliance.[110] As noted, the Board specifically held in its seminal

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decisions/2013/dab2507.pdf, *rev'ing* ALJ Dec. No. CR2617 (2012), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2012/cr2617.pdf; Pleasant View Ctr., DAB Dec. No. 2488, 1 (Dec. 6, 2012), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2012/dab2488.pdf, *rev'ing* ALJ Dec. No. CR2546 (2012), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2012/cr2546.pdf; Elant at Fishkill, DAB Dec. No. 2468, 1-2 (July 11, 2012), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2012/dab2468.pdf, *rev'ing* ALJ Dec. No. CR2465 (2011), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2011/cr2465.pdf; Va. Highlands Health Rehab. Ctr., DAB Dec. No. 2339, 1 (Sep. 30, 2010), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2010/dab2339.pdf, *rev'ing* ALJ Dec. No. CR2083 (2010), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2010/cr2083ok.pdf; Holy Cross Vill. at Notre Dame, Inc., v. CMS, DAB Dec. No. 2291, 1 (Dec. 21, 2009), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2009/dab2291.pdf, *rev'ing* ALJ Dec. No. CR1951 (2009), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2009/CR1951.pdf; Ill. Knights Templar Home v. CMS, DAB Dec. No. 2274, 1 (Sep. 30, 2009), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2009/dab2274.pdf, *rev'ing* ALJ Dec. No. CR1879 (2009), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2009/CR1879.pdf; St. Catherine's Care Ctr. of Findlay, Inc., v. CMS, DAB Dec. No. 1964 (Feb. 25, 2005), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2005/dab1964.htm, *rev'ing* ALJ Dec. No. CR1190 (2004), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2004/CR1190.htm; Lebanon Nursing & Rehab. Ctr. v. CMS, DAB Dec. No. 1918 (April 19, 2004), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2004/dab1918.html, *rev'ing* ALJ Dec. No. CR1069 (2003), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2003/CR1069.html.

110. *See* Hillman Rehab. Ctr. v. HCFA, DAB Dec. No. 1611 (Feb. 28, 1997), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/1997/dab1611.html, *aff'd*, Hillman Rehab. Ctr. v. HCFA, No. 98-3789 (D.N.J. May 13, 1999) (unpublished opinion); Cross Creek Health Care Ctr. v. HCFA, DAB Dec. No. 1665 (July 14, 1998), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/1998/dab1665.html. At least one old Board decision indicated that CMS had the burden to offer evidence regarding each deficiency it presses at the hearing (or else unsupported citations would be set aside). *See* W. Care Mgmt. Corp. v. CMS, DAB Dec. No. 1921 (May 10, 2004), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-

Hillman case that if CMS fails to meet this burden, then the petitioner prevails even if it offers no evidence at all.

However, the Board's application of this rule is at best unclear. First, as noted above, the Board does not allow an ALJ to render the equivalent of a directed verdict after CMS' case, thus essentially vitiating that aspect of *Hillman*.[111]

Second, as discussed above, the APA provides that the "proponent of a rule or order" bears the burden to sustain that order, but the Board has held, variously, that it is not subject to the APA rules regarding burdens of proof at all. Or, if the Board addresses APA burdens at all, it says that it is the petitioner who is the "proponent of an order" *relieving* it of the sanction—which obviously is not the intent of Section 556(d)—and so the petitioner bears the burden of "persuasion" that it was in compliance with whatever regulation is at issue.[112]

Thus, in some recent cases, the Board has absolved CMS from coming forward with *anything* at a hearing beyond the Statement of Deficiencies (which, the Board says, can be taken as "evidence" *of its contents),* and thus it is the petitioner's burden to *disprove* CMS' allegations.[113] As noted above,

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decisions/2004/dab1921.html. However, the Board now says that it can uphold a sanction if CMS manages to offer a prima facie case on *any* cited deficiency, and that the remaining citations simply will remain on the record, with the petitioner's challenge undecided. Plott Nursing Home v. CMS, DAB Dec. No. 2426 (Dec. 6, 2011), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2011/dab2426.pdf.

111. Although, the Board does require that the petitioner nevertheless make a motion to that effect on the ground that CMS failed to demonstrate a prima facie case, or else the argument is deemed waived.

112. *See*, *e.g.*, Batavia Nursing & Convalescent Inn v. CMS, DAB Dec. No. 1911 (Mar. 1, 2004), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2004/dab1911.html.

113. *See*, *e.g.*, Southpark Meadows Nursing & Rehab. Ctr., DAB Dec. No. 2703 (May 20, 2016), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2016/dab-2703.pdf. The application of this rule is demonstrated in cases such as Golden Living Ctr.—Riverchase v. CMS, DAB Dec. No. CR2012 (Sept. 30, 2009), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2010/dab2314.pdf, *rev'ing* ALJ Dec. No. 2012 (2009), in which an ALJ held that CMS had failed to establish a prima facie case of noncompliance where CMS' witnesses could not explain how a resident fell or suffered an injury during a transfer, but the Board reversed and held that it was the facility's burden to demonstrate that its staff had *not* violated any regulation.

ALJs will sometimes sustain deficiencies even where CMS offers *no* evidence beyond a Statement of Deficiencies.[114]

The Board has also held that CMS has no burden to produce any specific evidence to support an "immediate jeopardy" determination—even though the plain language of the regulation, 42 C.F.R. § 488.301, recites specific elements: noncompliance that "*has caused* or *is likely to cause death or serious harm*." Likewise, the Board holds that it is the petitioner's burden to demonstrate that the determination is "clearly erroneous."[115] Some poorly worded Board Decisions even suggest that some ALJs apply this rule to find a "presumption" in favor of the *merits* of any "immediate jeopardy" citation as well.[116]

At the same time, 42 U.S.C. § 1320a-7a(e), which governs appeals of CMPs, specifically provides that the standard of review of a determination of noncompliance is the traditional "substantial evidence in the record, taken as a whole," with factual disputes determined by a "preponderance of the evidence." The Board's "Guidelines for Review" provide that the same standard governs the administrative review.[117]

Again, however, the Board does not follow these rules. First, it typically says that it requires only "substantial evidence" to uphold CMS "findings" (allegations), which is a far lower standard than the statute actually requires, and which allows an ALJ to disregard a facility's evidence supporting a factual or legal defense.[118] Thus, in recent cases, ALJs have rejected clinicians'

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114. *See*, *e.g.*, Donelson Place Care & Rehab. v. CMS, ALJ Dec. No. CR5132 (2018); Life Care Ctr. of Merrimack Valley v. CMS, CR4965 (Nov. 6, 2017), https://www.hhs.gov/sites/default/files/alj-cr4965.pdf.

115. 42 C.F.R. § 488.301; *see*, *e.g.*, Daughters of Miriam Ctr. v. CMS, DAB Dec. No. 2067 (Feb. 9, 2007), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2007/dab2067.pdf (holding that the Social Security Act *prohibits* CMS from offering evidence in support of an "immediate jeopardy" determination).

116. *See*, *e.g.*, Century Care of Crystal Coast v. CMS, DAB Dec. No. 2076 (April 10, 2007), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2007/dab2076.pdf, *aff'ing* ALJ Dec. No. CR1488 (2006).

117. 42 U.S.C. § 1320a-7a(e); The courts *do* agree with this rule. *See*, *e.g.*, Woodstock Care Ctr. v. Thompson, 363 F.3d 583, 588 (6th Cir. 2003).

118. According to one court:

> There is a notable difference between "substantial evidence" and "substantial evidence in the record as a whole." "Substantial evidence" is merely such "relevant evidence that a reasonable mind might accept as adequate to support a conclusion." "Substantial evidence on the record as a whole," however, requires a more scrutinizing analysis. In the review of an administrative decision, "the substantiality of evidence must take into account whatever in the record fairly

reliance on formal clinical standards promulgated by professional organizations such as the American Diabetes Association and the American Medical Directors Association as "irrelevant" to CMS' enforcement prerogatives.[119] They have rejected considering the findings and analysis of State ALJs in parallel State appeals (even though the Supreme Court has held that federal administrative agencies must apply "issue preclusion" rules such as res judicata and collateral estoppel to prior state decisions).[120] They now routinely second-guess clinical decisions by residents' physicians, pharmacists and other professionals, and then impute liability for such "errors" to facilities.[121] They have based sanctions on critiques of apparently unremarkable facility policies.[122]

More importantly, the Board has stated in several recent Decisions that it considers ALJ and Board review of *both* CMS' factual allegations and legal conclusions to be "de novo."[123] As noted above, the Board says that it does *not* consider its review "restricted to the facts and evidence that were available to CMS when it made its decision," nor "how or why CMS decided to impose

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> detracts from its weight." Thus the court must also take into consideration the weight of the evidence in the record and apply a balancing test to evidence that is contradictory.

Gavin v. Heckler, 811 F.2d 1195, 1199 (8th Cir. 1987) (citations omitted).

119. *See*, *e.g.*, Oak Ridge Ctr. v. CMS, ALJ Dec. No. CR4865 (June 13, 2017), https://www.hhs.gov/sites/default/files/alj-cr4865.pdf.

120. *See*, *e.g.*, Rockcastle Health & Rehab. Ctr. v. CMS, ALJ Dec. No. CR4926 (Aug. 17, 2017), https://www.hhs.gov/sites/default/files/alj-cr4926.pdf. *Compare* Astoria Fed. Sav. & Loan Ass'n v. Solomino, 501 U.S. 104, 107 (1991); Kremer v. Chem. Constr. Corp., 456 U.S. 461 (1982); Parklane Hosiery Co. v. Shore, 439 U.S. 322 (1979); United States v. Utah Constr. & Mining Co., 384 U.S. 394 (1966); Stallings v. Goshen Dairy Stores, Inc., 89 F.3d 835 (6th Cir. 1998); E. Food & Liquor, Inc. v. United States, 50 F.3d 1405 (7th Cir. 1995); Darden v. Ill. Bell Tel. Co., 797 F.2d 497, 504 (7th Cir. 1986); Jackson v. Ky. Cabinet for Human Res., 774 F.2d 1162 (6th Cir. 1985).

121. *See*, *e.g.*, Golden Living Ctr.—Superior, DAB Dec. No. 2768 (Feb. 3, 2017), https://www.hhs.gov/sites/default/files/board-dab2768. (The facility violated regulation by following the Medical Director's decision—following a specific State guideline—not to order prophylactic Tamiflu until several residents diagnosed with flu); Asistencia Villa Rehab. & Care Ctr. v. CMS, ALJ Dec. No. CR4947 (Oct. 5, 2017), https://www.hhs.gov/sites/default/files/alj-cr4947.pdf (The facility violated a regulation by following a physician's order to administer medications that ALJ read "black box warning" to restrict).

122. Golden Living Ctr.—Trussville v. CMS, ALJ Dec. No. CR4916 (Aug. 11, 2017), https://www.hhs.gov/sites/default/files/alj-cr4916.pdf (A nurse followed facility policy by seeking help to deal with an intoxicated visitor).

123. Historically, and as recently as 2004, the Board specifically said that its review was *not* de novo. N. Mont. Care Ctr. v. CMS, DAB Dec. No. 1930 (2004). The Board has never made public the reason for this fundamental change in position.

remedies," and so it says it has the authority to sustain sanctions on new theories or grounds that a petitioner never had the opportunity to challenge.[124]

The Board also does not consider its decisions to be "precedential," and so ALJs and the Board frequently render conflicting decisions on even the most basic procedural and substantive issues.[125] And the Board specifically has held that it is not bound by CMS' "Interpretive Guidelines" set forth in the "State Operations Manual."[126] As a result, the case reports are filled with decisions that announce diametrically opposite requirements based on near-identical facts, or results that are inconsistent with commonly accepted current standards of practice.[127]

In some case reports, it is impossible to determine the actual evidentiary basis for a decision, since both ALJs and the Board routinely announce that the petitioner has offered "no evidence" on an issue, or that petitioner's evidence and witnesses are "unpersuasive." But some reviewing courts have suggested that there are due process limits to this sort of subjective decision-making, and that CMS and the Board cannot impose sanctions without clear

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124. Britthaven of Chapel Hill v. CMS, DAB Dec. No. 2284 (Nov. 17, 2009), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2009/dab2284.pdf. This position is contrary to the seminal APA case *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402 (1970), in which the Supreme Court held that agency action taken on one ground may not be sustained on a "post hoc rationalization" first articulated during an appeal of the action.

125. *See*, *e.g.*, W. Tex. LTC Partners, Inc., d/b/a Cedar Manor, DAB Dec. No. 2652 (Sept. 1, 2015), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2015/dab-2652.pdf; Green Oaks Health & Rehab. Ctr., DAB Dec. No. 2567 (Mar. 31, 2014), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2014/dab2567.pdf; Lopatcong Ctr., DAB Dec. No. 2443 (Mar. 6, 2012), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2012/dab2443.pdf; Universal Healthcare—King v. CMS, DAB Dec. No. 2383 (June 3, 2011), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2011/dab2383.pdf.

126. Foxwood Springs Living Ctr. v. CMS, DAB Dec. No. 2294 (Dec. 31, 2009), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2009/dab2294.pdf. Petitioners frequently argue that the Interpretive Guidelines are not binding law because CMS did not promulgate them according to the notice and comment provisions of the Administrative Procedure Act (which is an accurate recitation of the law). In many instances, the Interpretive Guidelines do provide a useful analytic structure for reviewing evidence of compliance, but some ALJs reject them even for that purpose.

127. *See*, *e.g.*, Oak Ridge Ctr. v. CMS, ALJ Dec. No. CR4865 (June 13, 2017), https://www.hhs.gov/sites/default/files/alj-cr4865.pdf (rejecting American Diabetes Association guidelines, and testimony by author of such guidelines).

prior notice of the standards to which a facility will be held. However, the Board routinely rejects such due process limits on its decision making.[128]

The Board routinely holds that CMS need not offer evidence on every deficiency it cited in support of a sanction and that ALJs need not address every deficiency a petitioner contests, if CMS argues, and the ALJ can find, that a sanction could be, or can be, supported by fewer than all of the originally cited deficiencies. One court specifically has rejected this policy,[129] one has questioned it,[130] and at least one has sustained it.[131]

And the Board routinely holds that misstatements of evidence or standards of care by ALJs constitute "harmless error."[132]

V. ANALYSIS AND RECOMMENDATIONS

No informed observer would argue that the overall quality of care in nursing facilities is worse today than it was in 1987.[133] Given the advances in medical science, there are many residents today who would not even have been alive thirty years ago with similar levels of physical or mental debility. Nurse training is far better today than thirty years ago; clinical systems are more robust; there are many more physicians who have expertise and

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128. *See*, *e.g.*, Carrington Place of Muscatine v. CMS, DAB Dec. No. 2321 (June 25, 2010), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2010/dab2321.pdf.

129. Plott Nursing Home v. Burwell, 779 F.3d 975 (9th Cir. 2015).

130. Grace Healthcare of Benton v. DHHS, 589 F.3d 926 (8th Cir. 2009).

131. Claiborne-Hughes Health Ctr. v. Sebelius, 609 F.3d 839 (6th Cir. 2010).

132. *See*, *e.g.*, Longwood Healthcare Ctr., DAB Dec. No. 2394 (June 30, 2011), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2011/dab2394.pdf; Life Care Ctr. of Tullahoma v. CMS, DAB Dec. No. 2304 (March 5, 2010), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2010/dab2304 (The ALJ improperly held that the standard of care requires consultation with physician before providing diabetes care per protocol, but the deficiency critiquing protocol was nevertheless upheld); Plum City Care Ctr. v. CMS, DAB Dec. No. 2272 (Sep. 29, 2009), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2009/dab2272.pdf.

133. As noted in the text, the 1986 IOM Report focused on structural aspects of "quality"—staffing, formalized assessments and care plans, resident rights, and the like. Today, CMS publishes "quality indicators" collected from aggregate assessment data that include items such as the number of residents who have fallen, the number who have new or worsened skin breakdowns, the number who use psychotropic medications, etc. *See Quality Measures*, CTRS. FOR MEDICARE & MEDICAID SERVS. (last updated Mar. 5, 2019), https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits/nhqiqualitymeasures.html. Whether or not such data are useful in the aggregate, they rarely offer insights into the care of specific residents.

experience in treating geriatric patients nearing the end of life; many facilities employ nurse practitioners, who barely existed thirty years ago; and even the most remote "mom and pop" facility has access to state of the art clinical systems, electronic medical records, expert consultants, and the like, that were not widely available in pre-Internet days.

The regulatory process arguably has not kept up with these developments, but more to the point of this paper, ALJ and Board Decisions continue to be based upon broad assertions about noncompliance similar to those CMS made decades ago, reinforced by "presumptions" that such arguments overcome a petitioner's evidence, even about current standards of care.

A principal reason that the enforcement process has not been able to address this disconnect is the unwillingness of the Secretary of Health and Human Services and his Appeals Board to require and employ, respectively, the rigorous standard of review the APA requires. As suggested above, regulation of health and safety is a vital government function, and the government ought to be able to use the enforcement process to weed out poor facilities. CMS *should* win every case it brings on the merits, not by cutting corners or restricting review, but because surveyors, supervisors, ALJs and the Board focus on enforcement of clear operational and clinical standards.

Instead, both surveyors and ALJs increasingly see themselves as armed with general warrants to critique specific professional judgments and facility "systems"—sometimes without regard to actual standards of care—and to work backward from unwanted resident outcomes to find some regulatory violation, which may or may not have caused the outcome, in order to impose blame. As a result, the enforcement process has increasingly drifted away from applying accepted clinical and quality standards to identify facilities that do not or cannot provide appropriate care. Instead, the process has drifted toward rooting out and punishing real or perceived errors, omissions and bad outcomes, no matter the cause, how isolated, or how implausible it may be that a cited error could cause any actual harm to one or more residents.[134]

So why do facilities even bother appealing, and what is to be done?

At least until recent years, facilities did regularly win appeals. Surveyors sometimes do exaggerate or misunderstand the facts, and State Survey Agencies, CMS and ALJs do misapply regulations.[135] Occasionally, an ALJ

134. *See*, *e.g.*, The Bridge at Rockwood v. CMS, ALJ Dec. No. CR4978 (Nov. 30, 2017), https://www.hhs.gov/sites/default/files/alj-cr4978.pdf (making a wide-ranging critique of facility's hiring, admission, care planning, staffing, and supervision "systems" not directly related to resident-to-resident altercation ostensibly at issue).

135. *See*, *e.g.*, Heartland Health Care Ctr.—Kendall v. CMS, ALJ Dec. No. CR4704 (Sep. 15, 2016), https://www.hhs.gov/sites/default/files/alj-cr4704.pdf (holding the facility not

holds that cited noncompliance was technical, or could not pose the risk of more than minimal harm, and thus could not support a sanction.[136] An appeal may reduce a huge penalty to one of more manageable size. For instance, some appeals challenge only the duration of lengthy "per diem" CMPs. In those cases, the facility concedes noncompliance but asserts that it corrected the deficiencies and resumed compliance sooner than CMS says—and some petitioners do prevail in such cases.[137] ALJs or the Board sometimes do find that the amount of a CMP is unreasonable.[138] And the actual audience for an administrative appeal may be the Court of Appeals, as several recent Court decisions limit the ability of CMS and the Board to impose sanctions based on ad hoc standards.[139]

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responsible for a resident falling from her wheelchair while her son was pushing her around the facility grounds); Kingsville Nursing & Rehab. Ctr. v. CMS, DAB Dec. No. 2234 (Mar. 19, 2009), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2009/DAB2234.pdf, remanding CR1832 (2008) (holding that ALJ improperly interpreted facility documents); Lake Country Nursing Ctr. v. CMS, ALJ Dec. No. CR2380 (June 6, 2011), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2011/cr2380.pdf (finding that the evidence did not support CMS' argument about timing of resident illness); Country Hills Health Care v. CMS, ALJ Dec. No. CR2291 (Dec. 13, 2010), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2010/cr2291.pdf (holding the fatal accident unforeseeable); Life Care Ctr. of Jefferson City v. CMS, ALJ Dec. No. CR2115 (Apr. 20, 2010), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2010/cr2115.pdf (setting aside a citation where resident suffered sudden unexpected death); Quality Care Health Ctr. v. CMS, ALJ Dec. No. CR2101 (Apr. 1, 2010), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2010/cr2101.pdf (finding that the evidence showed that the nurse did consult with a physician on a timely basis regarding the bleeding).

136. *See*, *e.g.*, Bella Vista Healthcare Ctr. v. CMS, ALJ Dec. No. CR2451 (Oct 12, 2011), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2011/crd2451.pdf (holding the notice of transfer was technically inadequate, but finding that the resident had actual notice and chose a new facility, so there was no risk for harm); Heritage Healthcare & Rehab. Ctr. v. CMS, ALJ Decision No. CR2116 (Apr. 20, 2010), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2010/cr2116.pdf (finding that the hot water exceeded the standard, but it was not hot enough to cause harm).

137. *See*, *e.g.*, The Springs at the Watermark v. CMS, ALJ Dec. No. CR5064 (2018) (sustaining the noncompliance but reducing the duration and CMP); Kindred Transitional Care and Rehab. – Greenfield v. CMS, ALJ Dec. No. CR4659 (July 12, 2016), https://www.hhs.gov/sites/default/files/static/dab/decisions/alj-decisions/2016/cr4659.pdf, *aff'd*, DAB Dec. No. 2792 (2017) (same).

138. *See*, *e.g.*, Life Care Ctr. of Tullahoma v. CMS, DAB Dec. No. 2304 (Mar. 5, 2010), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2010/dab2304.pdf.

139. Plott Nursing Home v. Burwell, 779 F.3d 975 (9th Cir. 2015); Elgin Nursing & Rehab. Ctr. v. DHHS, 718 F.3d 488 (5th Cir. 2013); Grace Healthcare of Benton v. DHHS, 589 F.3d

Moreover, there are several collateral reasons nursing facilities continue to contest deficiencies and sanctions they believe are unwarranted, even if an appeal to the Board is unlikely to be successful. Survey findings, even if unwarranted, can and do support civil actions;[140] Inspector General investigations;[141] "worthless services" claims; a host of collateral state and federal administrative consequences, including reimbursement penalties, adverse certificate of need consequences (that is, requests for approval of new facilities or services);[142] "special focus facility" designation (increased survey attention to facilities that have had especially bad survey histories);[143] poor public ratings,[144] and the like. Some states base licensure sanctions on specific survey citations.[145] Most commercial insurers limit participation in provider

926 (8th Cir. 2009); Emerald Shores Health Care Assocs. v. DHHS, 545 F.3d 1292 (11th Cir. 2008). *See also*, Cal Turner Extended Care Pavilion v. DHHS, 501 Fed. Appx. 502 (6th Cir. Oct. 5, 2012). In one recent remarkable case, a Court of Appeals panel informed CMS during the hearing that it was not inclined to uphold an "abuse" finding and that CMS should settle the case (which it did). Oral Argument, Ridgecrest Healthcare v. Burwell, No. 14-75538 (9th Cir. Oct. 20, 2016), available on the Court's website at https://www.ca9.uscourts.gov/media/view_video.php?pk_vid=0000010401.

140. *See*, T. Andrew Graham & Joseph Bianculli, "The Intersection of Regulatory and Personal Injury Litigation," a paper prepared for American Health Lawyers Association Long Term Care and the Law Program, Feb. 2015, available at healthlawyers.org.

141. At any given time, the DHHS Inspector General has several active investigations of general nursing facility operational issues underway. *See Active Work Plan Items*, U.S. DEP'T OF HEALTH & HUMAN SERVS., OFFICE INSPECTOR GEN., https://oig.hhs.gov/reports-and-publications/workplan/active-item-table.asp. The OIG also conducts investigations of individual facilities, sometimes based on adverse survey findings.

142. For instance, many states review the "track record" of applicants for new services or acquisitions, and some specifically ask applicants to report adverse survey findings at existing facilities. *See*, *e.g.*, Oklahoma certificate of need procedures and forms at ok.gov/health/Protective_Health/Health_Facility_System_/Nursing_Home_Certificate_of_Need/#UnofficialCONRule.

143. *See* https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html.

144. CMS publishes "ratings" on a one-to-five "star" system based on, among other things, survey citations, staffing data, and certain other criteria. See *Nursing Home Compare*, MEDICARE. GOV, medicare.gov/nursinghomecompare. Nationwide, the ratings are basically on a bell curve, with relatively few "one star" and "five star" facilities, but due to quirks in the calculation process, the ratings vary considerably from state to state and within states. There are many areas that have no four- or five-star facilities. Moreover, one bad deficiency can adversely affect the published rating for several years.

145. For instance, the Texas Nursing Facility Licensure Act, Section 242.061 of the Texas Health and Safety Code, provides for mandatory license revocation if a facility is cited for three "immediate jeopardy" "abuse or neglect" citations in three years—but only after final appeals are completed. TEX. HEALTH AND SAFETY CODE § 242.061(a-2)(1).

networks to facilities that have good survey records.[146] Evidence and argument from even unsuccessful appeals—especially surveyor testimony that otherwise is unavailable in discovery in civil proceedings—may be useful for such collateral proceedings (and some defense counsel encourage appeals of enforcement sanctions that could have civil counterparts for that reason). The principal reason to appeal may well be psychological, that is, to support staff, who sometimes simply need someone to hear their side of the story.

The reality is that some version of the current survey and enforcement system is likely to remain in place indefinitely, even though the enforcement process has arguably failed even on its own terms, as it does not—and, as currently structured and operated, cannot—reliably identify consistently poorly performing facilities, which was Congress's goal when it enacted OBRA '87, and which seems a reasonable goal today.[147] For instance, under the current system, surveyors could inspect two facilities next door to one another, both of which say they specialize in rehabilitation after hip replacements. One might send every resident home happy and well within a couple weeks; the other might send many residents back to the hospital with infections, generate numerous complaints, and the like. However, because the enforcement and appeal process as currently operated does not distinguish them on those bases, surveyors could cite the facility that every reasonable person would consider to be "good" for (perhaps even trivial) noncompliance, but not cite the "bad" facility for anything—and the Board would have no problem with that result.[148]

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146. For instance, most commercial insurance networks require nursing facilities to maintain three-star, or even four-star CMS ratings (*supra* note 144) to participate in preferred provider networks.

147. For instance, ALJs frequently impose enhanced sanctions based on a facility's supposedly poor "history" under 42 C.F.R. § 488.438(f)(1), even though nearly every facility is cited for some noncompliance every year. In one recent case, an ALJ sustained a termination action because of a series of supposedly uncorrected deficiencies, even though the evidence showed that a CMS official told the SSA to "go back as far as you need to find something," and so the SSA simply kept re-citing the same (trivial) citations, including examples that predated previously-accepted corrective actions. Donelson Place Care & Rehab. Ctr. v. CMS, ALJ Dec. No. CR 5132 (2018).

148. The author has been using this hypothetical example for many years, and never once has a CMS official or counsel objected that it is not true. In fact, some research suggests that not only is there no relationship between the current survey and enforcement process and traditional measures of "quality," but, perversely, there may even be an *inverse* relationship; that is, that there is no correlation between survey citations and tort findings of poor quality. R. Tamara Konetzka, et al., *Malpractice Litigation and Nursing Home Quality of Care,* 48 HEALTH SERVS. RES. 1920, (2013); David G. Stevenson et al., *Does Litigation Increase or Decrease Health Care Quality*?, 51 MED. CARE 430 (2013); David M. Studdert et al.,

The result is that CMS now routinely tries sloppy cases based on little more than a surveyor's disagreement with—or even lack of knowledge about—specific clinical decisions nurses or even physicians have actually made; speculation about potential adverse outcomes or hypothetical harm; emotional appeals; or boilerplate assertions to the effect that facilities must protect residents against "neglect," and the like. This practice is plainly encouraged by the Board's result-oriented decisions.

It is hard to believe that this practice would have developed, or would continue, if the Board applied traditional APA standards in appeals. Conversely, application of APA standards would require—and should require—changes to certain Board practices and policies,

First, the Secretary of Health and Human Services should instruct his Board to abandon its "policy" that CMS has no real burden to demonstrate *non*compliance but may impose sanctions based only on a "presumption" that every allegation and conclusion by every surveyor set forth in a Statement of Deficiencies—that is, the charging document—is correct. The Board says that this "presumption" is an artifact of its "policy" that a petitioner challenging a CMS action has the burden *throughout the proceeding* to demonstrate compliance. But the APA specifically provides that CMS, as proponent of an order imposing a sanction, has the burden to demonstrate the evidentiary and legal basis for its order *before* the petitioner has any obligation to offer any evidence or argument.[149] That rule puts the burden of demonstrating *non*compliance, and extracting penalties, squarely on the party, CMS, that is charged by law with an enforcement role.[150]

Second, the Secretary should instruct his Board to abandon its "de novo" review policy, at least as currently employed to mean that ALJs and the Board have some sort of implied general warrant to oversee and intervene in the care of specific residents rather than reviewing the findings of fact and conclusions of law of the agency that is tasked with that process.[151] As a

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Relationship Between Quality of Care and Negligence in Nursing Homes, 364 NEW ENG. J. MED. 1243 (2011).

149. As noted above, the Board actually held in *Hillman* that CMS, as proponent of an order imposing a sanction, does have the burden to demonstrate a "prima facie case" of noncompliance *before* the burden of proceeding shifts to the petitioner to offer a defense or demonstrate compliance. Hillman Rehab. Ctr. v. HCFA, DAB Dec. No. 1611 (Feb. 28, 1997), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/1997/dab1611.html, *aff'd*, No. 98-3789 (D.N.J. 1999). However, the Board abandoned the *Hillman* rule about ten years ago.

150. One Court of Appeals has noted that the enforcement process is "quasi-criminal" in nature. Grace Healthcare of Benton v. DHHS, 589 F.3d 926, 932 (8th Cir. 2009).

151. *See*, *e.g.*, Avon Nursing Home, DAB Dec. No. 2830 (Nov. 6, 2017), https://www.hhs.gov/sites/default/files/board-dab-2830.pdf.

practical matter, ALJs and Board members have no special medical or health care operations training; indeed, their experience in the area is limited to what they learn in the course of specific appeals, yet they increasingly base decisions upon their views of how nursing facilities "ought to" operate (sometimes irrespective of actual CMS policy) and, as noted, sometimes even second-guess specific medical judgments and decisions by physicians and nurses.

As a matter of administrative law, the Board has no statutory or regulatory authority to impose sanctions "de novo" nor to initiate or restate a charge of noncompliance. But the Board says that it is not bound by the Supreme Court's seminal case that holds that a reviewing tribunal may *not* substitute a "post hoc rationalization" for the basis set forth by the agency for its own decision.[152] According to the Board, that rule binds only the courts and not its administrative review. Thus, as discussed above, the Board has expressly abandoned any role as an independent reviewer of CMS' factual assertions and legal interpretations, and now sees itself as the final step in the enforcement process, where it can fix agency errors.[153] That is plainly not the function of the independent administrative—that is, pre-judicial—review that Congress contemplated in either the Social Security Act or APA—and that the Supreme Court has held is an element of due process in the administrative review context.[154] Vitiation of appeal rights in this manner would seem to pose both APA and due process issues.

The obvious practical question would seem to be, if the Board and its ALJs do not see themselves as providing independent review of agency actions, then who is to provide such review?

As noted, the courts are beginning to scrutinize ad hoc surveyor findings as well as the result-oriented shortcuts the Board employs during the appeal process.[155] The fact that the Board does *not* apply APA standards to its

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152. Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 402 (1971).

153. Golden Living Ctr.—Riverchase v. CMS, DAB No. 2314 (Apr. 12, 2010), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2010/dab2314.pdf; Beatrice State Dev. Ctr. v. CMS, DAB No. 2311 (Mar.31, 2010), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2010/dab2311.pdf; Britthaven of Chapel Hill v. CMS., DAB No. 2284 (Nov. 17, 2009), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2009/dab2284.pdf; Cal Turner Extended Care Pavilion v. CMS, DAB No. 2030 (May 25, 2006), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2006/dab2030.htm.

154. *See*, *e.g.*, Mathews v. Eldridge, 424 U.S. 319, 349 (1976).

155. This is a recent development. Before 2010 or so—that is, when the Board and its ALJs *did* exercise independent review of CMS actions—courts of appeals affirmed nearly every Board decision. Representative reported decisions include Windsor Place v. U.S. Dep't of

reviews can be—and sometimes is—asserted as a flaw in all of the administrative steps that precede Board action. As a result, more cases are being appealed to the courts of appeals that raise the fundamental APA issues discussed above.

However, while the courts have set aside some individual Board decisions, they have had difficulty designing and implementing effective remedies for *systemic* breakdowns of the agency's appeals processes. For instance, DHHS' parallel reimbursement disallowance appeal process has essentially ground to a halt under the weight of literally hundreds of thousands of pending appeals. A coalition of providers sought judicial intervention to break the logjam, and a district court ordered the Secretary of Health and Human Services to create a process to decide all of the pending appeals, but on a schedule that the Secretary argued was impossible to achieve. A split court of appeals panel reversed the district court order, ruling that the district court had not adequately addressed the Secretary's "impossibility" argument. However, the court did not disagree with the gist of the plaintiffs' argument that providers had a reasonable expectation that the agency would hear and decide their appeals within a reasonable time—all agreed that the providers would win or settle at least some of the stalled appeals—and so the agency's refusal even to address systemic delays that had the effect of tying up their money indefinitely was intolerable.[156]

As of the publication date of this paper, that specific case remains unresolved, but it is notable that a panel of the Fifth Circuit sustained another approach to resolving the same administrative breakdown. In that case, the district court held that the harm caused by delays in processing reimbursement appeals outweighed the government's interest in exhaustion of the administrative process, and so the court directed the Secretary not to recoup a facility's disputed reimbursement pending the administrative litigation.[157] The court distinguished the series of Supreme Court cases requiring exhaustion; according to the court, the interim remedy it devised balanced the petitioner's interest in avoiding harm caused solely by the

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Health & Human Servs., 649 F.3d 293 (5th Cir. 2011); Fal-Meridian, Inc. v. U.S. Dep't of Health and Human Servs., 604 F.3d 445 (7th Cir. 2010); Livingston Care Ctr. v. U.S. Dep't of Health & Human Servs., 388 F.3d 168 (6th Cir. 2004); Crestview Parke Care Ctr. v. Thompson, 373 F.3d 743 (6th Cir. 2004); MeadowWood Nursing Home v. U.S. Dep't of Health and Human Servs., 364 F.3d 786 (6th Cir. 2004); Woodstock Care Ctr. v. Thompson, 363 F.3d 583 (6th Cir. 2003); *and* Fairfax Nursing Home v. U.S. Dep't of Health & Human Servs., 300 F.3d 835 (7th Cir. 2002).

156. Am. Hosp. Assoc. v. Price, 867 F.3d 160 (D.C. Cir. 2017).

157. Family Rehab., Inc. v. Azar, 886 F.3d 496 (5th Cir. 2018).

agency's delays and the agency's interest in preserving its enforcement prerogatives.

These courts' focus on both the direct and indirect impacts of systemic administrative breakdowns is not a novel issue. As long ago as 1982, for instance, a court of appeals panel would have allowed Medicare beneficiaries appealing denial of coverage for a controversial medical procedure to avoid exhausting the appeal process where more than 400 consecutive claimants had won such appeals, with the Court holding that the delays and unnecessary litigation themselves triggered APA and due process rights (the Supreme Court did reverse on the exhaustion issue).[158] It is common in some judicial districts for judges or magistrates to award interim relief to Social Security claimants caught in the appeal morass. Thus, it seems likely that at some point, one or more judges will be offended by the Board's delays, prehearing "escrows," and, ultimately, its "facilities never win" policy, and they will intervene in a way that could erect significant roadblocks for the agency. There is no legal reason why a court offended by shortcuts in the Board's appeal process could not order the Secretary to fix such flaws, or could even allow petitioners to avoid the process in some circumstances.[159]

There really is no public policy that favors ad hoc and potentially heavy-handed judicial intervention into legitimate enforcement prerogatives. Thus, the respectful suggestion is that the sooner the Secretary and the Board recognize that they have good reason and means to improve the Part 498 appeal process—specifically, by rigorously applying APA standards in independent reviews of agency actions—the more likely they can insulate the results of that process against judicial second-guessing.

Moreover, perhaps ironically, many counsel to nursing facilities believe as a practical matter that the Board's outcome-oriented policies actually have the effect of *increasing* the number (and intensity) of appeals, as facility operators grow frustrated with seemingly arbitrary citations and penalties yet must exhaust the administrative appeal process before pursuing a judicial

158. Ringer v. Schweiker, 697 F.2d 1291, 1296 (9th Cir. 1982), *rev'd sub nom.* Heckler v. Ringer, 466 U.S. 602, 627 (1984).

159. In 2018, a group of related nursing facilities filed a motion to the Board to require an ALJ to decide a series of appeals—including a termination case—that had been tried more than two years earlier. The Board denied the motions on the ground that even though 42 C.F.R. § 498.74 requires ALJs to decide cases "[a]s soon as [is] practical," its regulations did not allow a petitioner to raise the issue before the Board. Ruling in Signature Healthcare of E. Louisville v. Ctrs. for Medicare & Medicaid Servs., Docket No. C-14-1127, Signature Healthcare of Pikeville v. Ctrs. for Medicare & Medicaid Servs., Docket No. C-14-1916, and Donelson Place Care & Rehab. v. Ctrs. for Medicare & Medicaid Servs., Docket No. C-15-2222. The Board's ruling was arguably appealable to the District Court, but the ALJ quickly issued a notice that notwithstanding the Board's ruling, he would—and did—decide the cases promptly thereafter.

challenge where they might prevail. As noted above, in a perfect world, CMS would win every appeal on the merits because it had announced clear guidance, the surveyor had carefully documented the alleged noncompliance, CMS meticulously tied evidence to controlling regulatory and clinical standards, and ALJs found facts and applied the law as the APA contemplates. That would be in the agency's best interest, but, more importantly, such a result would help ensure the best interests of the residents whom the agency is bound to serve.